Wisconsin Partnership Program Replication Manual

November 2003

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Glossary of Terms

ACSC – Ambulatory care sensitive conditions

Agency – Refers to any state or federal entity with which Partnership Programs interact

CBRF – Community Based Residential Facility

CMS – The Centers for Medicare and Medicaid Services

Consumers – Refers to people who are enrolled in or may need services from long-term care programs like the Wisconsin Partnership Program; may also be referred to as members or participants

DHFS – Wisconsin's Department of Health and Family Services

EQRO – External Quality Review Organization

IDT – Interdisciplinary Team consisting of consumers, nurse practitioners (NP), social workers (SW), registered nurse (RN), and team coordinators.

HCBS Waivers – Home and Community Based Services Waivers

Members – Refers to people who are enrolled in the Wisconsin Partnership Program; may also be referred to as consumers or members.

NP – Nurse practitioner

Organization – Refers to any potential Partnership Provider

PIP – Performance Improvement Projects

PCP – Primary Care Physician

Partnership – Refers to the Wisconsin Partnership Program

Provider – Community and Health Care service providers with whom Partnership Programs contract for services

RAD – Resource Allocation Decision-Making (RAD) Process

RN – Registered Nurse

WPP – Wisconsin Partnership Program

About The Authors

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Barbara Bowers is a Professor in the School of Nursing at the University of Wisconsin-Madison. She was one of the initial recipients of the Robert Wood Johnson Building Health Care Systems Grant that became The Wisconsin Partnership Program. Dr. Bowers directed the Partnership Research for the initial demonstration grant and has been involved in several other Partnership related research and development activities over the past 10 years.

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Sarah Esmond, MS, is the Research Program Manager at Center for Excellence in Long Term Care at the University of Wisconsin-Madison, School of Nursing. Sarah has been actively involved with the Partnership Program since 1995, and was one of the initial members of the Partnership Quality Research team (http://www.dhfs.state.wi.us/WIpartnership/QualityResearch.htm) that explored consumer and provider perspectives on consumer centered care. Sarah has nearly 10 years of experience conducting research in long-term care settings and has collaborated on or led numerous research initiatives focused on the provision of health and long term care, consumer centered care systems, and quality improvement.

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include comprehensive services to facilitate the planning, implementation, and ongoing support of innovative, managed care models that provide integrated health, long-term care and community-based services to targeted populations. As a part of this activity, Ms Graves has worked with Wisconsin's Partnership Program sites since the inception of the program, focusing on a variety of strategic and business development expansion activities. She also oversees TMG's comprehensive regulatory and compliance activities for Wisconsin-based managed care organizations licensed to serve commercial and government-payer populations. Prior to joining TMG, Ms. Graves served from 1988 to 1993 as the first Executive Director of the Association of Wisconsin HMOs (Association of Wisconsin Health Plans). She directed all aspects of government and regulatory activity for 23 Wisconsin-based health plans. Ms. Graves also served as Legislative Liaison for the Secretary of the Department of Health and Family Services, coordinating all the Department's legislation and administrative rule activity.

Marla Handy

Marla Handy, Ph.D., has over 20 years experience consulting with domestic and international nonprofit organizations in the areas of organizational and community development. Her research interests include public/nonprofit social service partnerships, nonprofit governance and interagency collaborations. She currently teaches in the School of Human Ecology, UW-Madison.

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Lynn Polacek, RN, MS is currently on per diem status with Elder Care of Dane County after her semi-retirement. She served as Elder Care's Clinical Nurse Specialist and

Quality Improvement Coordinator. Prior to that she was the Director of Clinical

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Partnership organizations on clinical practice issues, Interdisciplinary Team (IDT)

development, infrastructure, and quality improvement projects.

Part I.

Overview of Wisconsin Partnership Program:

The Philosophy, Design, & Experience

Chapter 1
Introduction to the Partnership Replication Manual

Background

The Wisconsin Partnership Program was developed with generous support from the Robert Wood Johnson Foundation under its Building Health Systems Initiative. Planning began in 1992, program development commenced one year later, and the first Partnership member enrolled in 1995. Every aspect of program planning and development reflected a commitment to an interdisciplinary approach, as well as a fundamental collaboration among the Wisconsin Department of Health and Family Services, the University of Wisconsin-Madison's School of Nursing research team, and private sector service delivery organizations. In addition, the mutual respect, appreciation, and continuing efforts of early participants were a significant component in the Partnership Program's success (See Appendix A for initial grant proposal narrative).

Purpose

The purpose of this manual is to assist individuals and organizations considering the adoption of a Partnership model to serve their long term care populations. Designed from the point-of-view of Partnership organizations, this document is a starting point from which you will decide whether the Partnership model is right for your purposes, population, organization, and circumstances. If Partnership is the right fit, this manual will guide your agency to prepare for the planning and development of a Partnership Program.

Specifically, the manual will addresses the following questions:

- Is Partnership the right model for the population my organization serves?

- Is Partnership a feasible model for the context in which I am considering it?

- What planning and preparation are necessary to maximize the chances of successful implementation?

- How do I go about establishing a Partnership Program?

- What challenges can I anticipate and how can I best prepare for them?

- Who should I select as planning partners?

- How can I best work with these partners?

The manual addresses each of these and other questions based primarily on the experience of current and former staff in the four Partnership Programs currently operating in Wisconsin. Each of these Partnership Programs was built on a community-based long-term care program; two were Independent Living programs serving mainly adults between 18 and 65 years old with disabling conditions, and two were built on existing Program of All-inclusive Care for the Elderly (PACE) sites. Consequently, the manual is written from that perspective. The manual may be less relevant for large health care organizations wishing to start a Partnership Program. However, there is much here to inform and guide a program developed within such an organization.

If you have questions as you read through the manual, or if want details about any aspect of Partnership Program development, contact any of the WI Partnership Programs for assistance or consultation (See Appendix B). Their experience and expertise will be helpful as you consider developing a Partnership Program.

In addition, the manual highlights the insights and experiences of the researchers and consultants involved in the initial development and evaluation of the Partnership Program, as well as various individuals who have worked with one or more of the Wisconsin Partnership sites over time. It is replete with wisdom from staff who participated in the planning, implementation, and evaluation of the Partnership sites in both rural and urban Wisconsin.

The manual primarily addresses aspects of planning and developing a Partnership Program and includes examples to illustrate some of the important considerations along the way. The appendices contain many useful forms developed and generously provided by the four Partnership sites. These can be used as templates in designing new programs, both to provide guidance and to reduce development time.

Development of the Manual

This manual was developed through an extensive review of Partnership documents generated between 1993 and 2003, a series of interviews with partnership staff at all Partnership sites, focus groups with Partnership management staff, and interviews with key individuals involved in developing the Partnership Programs.

Organization of the Manual

This manual is presented in two major parts, each with multiple chapters, case examples, and advice from experienced Partnership staff who designed, implemented, and now operate successful Partnership Programs in Wisconsin.

Part 1: The Philosophy, Design, & Experience

Part 1 of the Manual introduces the Wisconsin Partnership Program and provides a glimpse of the differences it can make for consumers. Chapter 1. Introduction provides background information, describes the purpose of the Partnership Program and the replication project, and orients readers about how to use this manual.

Chapter 2. The Human Side of the Partnership Program compares the experience of "Albert," a long-term care consumer in a "typical" long-term care program, with that of "Albert," a Partnership member. Although this section is quite brief, it will allow you to determine quickly whether it is worth the effort to keep reading. If you are compelled by the difference in Albert's life as a Partnership member, read on.

Chapter 3. The Philosophy of the Wisconsin Partnership Program includes a description of the philosophy guiding the Partnership Program, how the philosophy relates to the design of the program, and why other existing models, including PACE and Wisconsin Home and Community Based Services (HCBS) Waiver programs were determined to not have all the necessary components. It explains why the Partnership founders were determined to create a fully integrated program and how they would proceed with integration.

Chapter 4. The Partnership Model outlines the Partnership approach, providing details about its fully integrated funding streams, integrated provider network, approach to consumer-centered planning, and its unique interdisciplinary team.

Chapter 5. Partnership Outcomes focuses on outcomes related to the Partnership Program including cost effectiveness, decreased institutionalization and hospitalization, and consumer satisfaction.

Chapter 6. Target Population describes the populations for which the Wisconsin Partnership Program was built—low income, frail, chronically ill adults. This is not to suggest that the Partnership Program could not be applied to other populations, but it is important for readers to understand the general characteristics and potential service needs of the population for which the program was developed. This chapter also provides information on what organizations may need to consider if they plan to alter the Partnership design to meet the specific needs of other populations.

Part 2: Organization and Program Development

Part 2 focuses on the necessary steps toward Partnership Program adoption. Chapter 7. How a Partnership Program Changes a Manual of the manual discusses the impact of adopting a Partnership program and the accompanying changes that organizations might face throughout the planning and implementation processes.

Chapter 8. Steps to Program Adoption: Pre-feasibility outlines the careful planning and preparation required when an agency considers building a Partnership Program. This chapter addresses the first step to program adoption: a Pre-feasibility Study.

Chapter 9. Steps to Program Adoption: Preliminary External Feasibility and Relationship-building describes how the Preliminary External Feasibility and relationship

building phase of program adoption. It focuses on needs assessment, relationships with state agencies and departments and community stakeholders, and network development.

Chapter 10. Steps to Program Adoption: Full Feasibility Study discusses a range of issues related to the next step in program adoptions: a Full Feasibility Study. This chapter focuses on an agency's internal and community capacity for a Partnership Program. It reiterates the importance of building relationships with state staff and offers insight about developing contracts.

Chapter 11. Steps to Program Adoption: Capacity Development addresses the last step in adopting a Partnership Program: Capacity Development. Key areas of discussion include building internal capacity to support a Partnership Program (management structures, information and financial systems, expansion of agency board, contracting, and risk management) and developing external capacity, including relationship building with state and providers and establishing enrollment networks.

Special Features

Throughout the manual, quotes from current Partnership Program staff have been included as relevant to the discussion. Each of the individuals quoted in the **Voice of Experience** sections has considerable experience with some aspect of the Partnership Program and is considered one of the leaders in the overall Partnership effort.

Case examples are also included to illustrate and reinforce points made in various discussions. These are the real life reflections of how a Partnership Program is

developed. Some illustrate missteps and some achievements. Both are important to share.

Finally, **Decision Point Checklists** are provided at the end of Chapters 8-11. These checklists were crafted to help organizations think about whether to read on. They provide clear, tangible guides for considering whether Partnership is likely to be the right model for your organization. The checklists also help identify things that might need to be in place to maximize an agency's chances of success in implementation.

This manual provides an outline of the processes and information needed to decide whether or not to proceed with a Partnership model. It does not provide the level of detail needed to implement a Partnership Program. There is a list of experienced Partnership staff who can provide additional guidance on each of the specific processes described in the manual (See Appendix B). Feel free to contact these people; their insight will be valuable as you consider adopting a Partnership Program.

Chapter 2
The Human Side of the Partnership Program

Introduction

This chapter illustrates the differences a Partnership Program can make in the lives of the consumers you serve or are planning to serve. The case example below represents a composite of long-term care consumers, someone we are all familiar with, whose needs are not well matched to either traditional long-term care or health care systems. In this scenario, Albert can be seen falling through many of the usual cracks. Despite the best efforts of skilled, committed providers in multiple settings, Albert suffers the consequences of poorly designed systems. It reflects the impact of systems that are not well designed to serve long term care consumers.

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<u>Case Example</u>

Albert Harris, an 84-year-old man, has been living in the same home in his relatively quiet community for many years. Recently Albert has been having blackouts. This has prevented him from doing all the things he used to enjoy. He no longer makes a trip to the senior center on Wednesdays or takes his walk to the coffee shop on Friday mornings. He has even missed weekend dinners with his family. Albert is saddened by the loss of these activities.

As Albert's care manager, you have been trying and trying to get him an assistive device so he can get around his home with greater ease. In the meantime, you have tried to get more personal care hours than he currently is receiving. These extra hours are not getting approved because the personal care agency working with Albert has a high turnover rate. Workers often show up later than they are scheduled, so he misses important activities. You know Albert has medical problems that need attention. He has several medications. You know he doesn't take them all, but you are not sure what they are all for. You have called his physician several times. No phone call has been returned, although they promise to call back.

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Last week one of Albert's personal care workers called you. She says she went to Albert's home the week prior and he was not there. You write a note to look into it after your current workload has been taken care of. A few more days go by and the personal care workers have quit going to his home. You have finally tracked down that Albert was hospitalized. Evidently he spent nine hours in the emergency room while they tried to figure out what medications he was taking. He was in the hospital and was hallucinating. He was assessed as having dementia and has been tied down. His response was to fight and the gentle man you knew has become scared, angry, and aggressive. He hasn't been out of bed much as is becoming very weak.

Three weeks later you learn Albert was discharged to a nursing home that you know is not very good. He was sent there against his will. He is now depressed and confused. You believe that he needs a reason to live and that company and interesting activities will pull him out of this, but nothing seems to be done to achieve this. The primary care worker who can motivate him has been reassigned. The staff just tell you how understaffed they are. You try to have him sent home but are unable to convince the doctor and find a reliable set of providers in the community. His usual workers have already been reassigned.

Weaknesses of Long-term Care Systems

Anyone who has worked in long-term care is familiar with the frustrations experienced by consumers and service providers. Some of these concerns are captured in Albert's story. Traditional long-term care systems are simply not well designed to meet the needs of either consumers or providers. Some commonly occurring problems include:

- Long delays for services that are needed immediately

- Failure to approve services that are clearly necessary

- Poor follow through with approved services

- Poor communication across providers and systems

- Scheduling that is inconvenient for the consumer

- Unreasonable demands for care managers or providers to document, often

  repeatedly, the need for service

- Ongoing paper compliance requirements

- Lack of coordination between health care and community support systems leading to redundancy and inefficient service delivery

- Failure to honor consumer choice

Voice of Experience

Even the best providers, skilled and committed people, can't provide effective long-term care to consumers when "systems" are not aligned to do this.

These system problems have serious consequences for both consumers and providers. Consumers are forced to go without important services, undermining both the effectiveness of their care and the quality of their lives. Consumers who receive services from several providers or agencies must figure out how to coordinate these services and providers with each other. This can lead to confusion, exhaustion, and in many cases, deciding to go without important services. Consumers cannot always expend the time or energy required to organize and coordinate their services. Most frustrating is the knowledge that things *could* go much better if only the systems were better designed.

The same system problems have consequences for providers. Despite these problems, providers in both long-term support and health care try to "do the best they can under the circumstances." As frustrations mount, many providers do what long-term care consumers often do. They simply give up. Social workers stop calling local physicians who don't return their phone calls. Nurses stop advocating to keep frail older adults from being discharged from the hospital too soon. Physicians stop ordering services and

treatments that are repeatedly denied. One particularly unfortunate consequence of these system problems is that some of the best care managers and providers leave the work altogether. Continuing to care becomes a liability (See Appendix C).

Sometimes providers and long-term care workers blame each other for the problems and frustrations that are generated by the systems they work in. Nurses sometimes blame physicians for not being sensitive to a consumer's home situation, or they blame long-term care workers for not adequately encouraging a consumer to stick with a treatment program designed to keep the consumer out of trouble. Nurses sometimes blame patients/consumers for not cooperating with what is "obviously" in their best interest. Social workers blame nurses for not adequately appreciating how a treatment plan affects the consumer's quality of life and for limiting consumer choice because the nurse is too concerned about physical safety.

Care providers and care managers often survive by finding ways to come as close as possible to the outcome they know is best while remaining frustrated and unsatisfied that they can't do better. The Partnership research documented important, consistent differences in how nurses and social workers provide 'consumer centered' care. These differences can be used to enhance care in a highly integrated program. Otherwise, under different circumstances, the same differences become divisive and undermine care quality (See Appendix D).

The Partnership Approach

These are the frustrations that Partnership tries to prevent. By offering a different set of ground rules, the Partnership Program is designed to address the problems that lie at the heart of long-term care.

Partnership offers another way of doing business. Imagine if you had a close working relationship with health care providers and long-term support workers who also worked with your client? What if you worked in a program that had a single source of funding, and there was no prior authorization requirement? What if you could work in a system that was able to determine what is needed and just provide it? What if you were informed as soon as a consumer was hospitalized, had a medical crisis, or was being seen in a local emergency room?   What if you had the authority to demand that certain care was given or a standard of quality was met in a hospital or nursing home environment? What if you had the ability to supplement the care a consumer received in a hospital or nursing home setting? What if you were always notified before a consumer was discharged from a hospital?

The Wisconsin Partnership Program is designed to make these things possible. Below is the second "Albert" scenario. Albert is now enrolled in a Partnership Program. The scenario offers a snapshot of the impact the Partnership model has on a person's life and describes what can be *expected* as a Partnership member. It reflects the usual way of doing things in Partnership, not the exception.

Case Example

Albert Harris, an 84-year old man, has lived in the same home in a relatively quiet community for several years. He has recently been experiencing blackouts which have caused him to stop doing all the things he enjoys: Wednesday trips to the senior center, Friday walks to the coffee shop, and weekend dinners with his family. His previous care manager tried very hard to advocate for him and to provide more services, but the restrictions of the program limited her ability to be successful. She had heard of the Wisconsin Partnership Program (WPP) and made a referral.

The WPP Intake Team contacted Albert and enrolled him within 2 weeks. Albert's primary care physician (PCP) was on the provider list and had one other patient who was in WPP. Due to a miscommunication, she was unaware of Albert's blackouts. The Intake RN talked to the Partnership Interdisciplinary Team (IDT) including a nurse practitioner (NP), registered nurse (RN), and social worker about Albert's condition. The home care RN scheduled a visit with Albert to do an initial assessment including his knowledge and use of his medications. He discovered that Albert had been using his old medication bottles and was taking his anti-hypertensive and beta blocking medications incorrectly. The RN clarified the medication orders with the NP and filled med cassettes for Albert to use. The NP arranged for an appointment with the PCP and accompanied Albert to discuss his care with the physician. Medication adjustments were made, goals clarified, and the follow-up plan established. The NP would monitor and adjust medications as discussed with the PCP and consult her if any other problems arose. The RN made the changes to the med cassette and educated Albert on the changes. He also talked with Albert about safety precautions should Albert feel dizzy.

The social worker met with Albert and helped make arrangements for him to get a ride to the senior center and the coffee shop next week until he was safe to walk again after the medication adjustments. The social worker also talked with Albert's family, with his permission, and suggested that perhaps this weekend they bring dinner to Albert's house. She explained to them that the team would be reviewing Albert's personal care needs and coming up with a plan at next week's team meeting.

At the Partnership IDT meeting, the team reviewed the information and suggestions from the RN as to Albert's needs for personal care and the social worker's suggestions for housekeeping assistance and home delivered meals. They requested the assignment of one of the long-term personal care workers who was very good at observing and reporting information to the team. The RN commented on Albert's deconditioned state and the lack of safety and adaptive aids in his house. The team decided to get a physical therapy and occupational therapy in home consultation.

An alert sheet was completed for the on-call RN with the medication plan and suggestions for how to respond if Albert would suffer another blackout.   The RN, NP, and social worker all scheduled additional follow up visits to complete their in-depth initial assessments and to get to know Albert better and understand his goals and wishes. Albert was given a refrigerator magnet with the one number to call 24 hours a day for problems.

Over the course of the next several months, the IDT further explained the goals of the program and the services that were provided. They got to know Albert's likes, dislikes, preferences, fears and goals.

The NP performed a complete history and physical and wrote orders for Albert to get the health maintenance services that were established as standard. She communicated with the PCP to plan medical interventions that met Albert's needs and that were acceptable to him. Albert agreed that if he had future blackouts even after the medication changes, that further tests would be indicated. The NP and PCP acknowledged Albert's desire to avoid hospitalization if at all possible.

The RN educated Albert about his medications illnesses, and the interventions to manage them and assessed Albert's response. The RN also coordinated the in-home workers and evaluated how well the plan was meeting Albert's functional needs. She made sure others who Albert was in contact with also understood the medication plan, so they could assist Albert.

The social worker assessed Albert's living situation, support system, community connections and general coping. She talked with Albert about his fears, hopes and goals. Albert told her it was very important to him to feel "in control" and that he treasured his independence and ability to live in his own home. She assured Albert the IDT would support his goals and explained how the services offered would help him maintain and perhaps increase his ability to be independent. She stressed that timely reporting of changes to the IDT or on-call RN could result in early treatment and hopefully prevent ER visits and hospitalizations. Albert told the social worker about a friend of his who had been on life support machines after a stroke. He emphasized that he did not want to end his life that way. He admitted that he had not mentioned this to the NP when she met with him last week; he said he tries not to think about it too much." The social worker relayed the information to the NP, and they decided to do a joint visit with Albert to talk about his current health problems and to review his advance directive plans.

Six months after enrollment in the program Albert needed to be hospitalized for another blackout. The NP talked with the PCP to arrange the admission and then called the ER to alert them to Albert's arrival and the plan. She gave them her number for questions and updates and faxed Albert's History & Physical, problem list, and medication list to the ER. The social worker visited Albert in the hospital the next day to see how he was coping and to check in.

The NP stopped in to see Albert and talked with the attending MD about the results of his tests. The RN put all the home care services on hold until Albert's discharge was known and telephoned Albert to see how he was doing. The team would discuss his discharge needs and plans in their team meeting the next day.

Conclusion

Because of the Partnership Program, Albert was able to receive the kind of care described above, return home and resume the activities he loved. What's more, he received ongoing, integrated support from a team of professionals whose combined expertise and ongoing collaboration resulted in stabilized and improved health for Albert, reduced risk of hospitalization and institutionalization, and maximized independence and ability to live the life Albert desired. In the Partnership program, the providers are working as a team, in a system that brings people and resources together rather than keeping them separate (See following page for graphic of Long Term Care Models from the Consumer Perspective).

Insert Long Term Care Models from the Consumer Perspective Chart

Chapter 3
The Philosophy of the
Wisconsin Partnership Program

Introduction

The founders of the Partnership Program had a vision of what long-term care could be. They also had considerable experience with how long-term care systems actually worked and were committed to creating a system very different from the ones they knew and worked in. The Wisconsin Partnership Program was initiated to create a system for frail, vulnerable, seriously ill adults that was:

1. Highly coordinated across providers, settings, and over time,

2. Comprehensive in services of high technical quality,

3. Consumer centered,

4. Delivered in a way that led to a positive experience for consumers,

5. Appropriate for non-elderly as well as for elderly consumers, and

6. Cost effective.

This was the vision that guided the designers of the Partnership Program. Having years of collective experience in the provision and oversight of long-term care, the initial Partnership planning team had seen how systems lacking these characteristics undermined the quality of care for this vulnerable population and frustrated the providers caring for them. Shortcomings in the current systems were especially notable in the lack of care coordination and in the provision of patient-centered care. High technical quality was the attribute most commonly found in both health care and long-term care programs. The other six attributes (above) were much harder to find.

Considering Other Models

Designing and building a new model of long-term care is a costly, labor-intensive endeavor. Such an undertaking would only make sense if the current systems could not achieve most or all of the six system characteristics listed above. The Partnership planning team was convinced that creating such a new system was well worth the effort. They believed that long-term care could be shifted from the ineffective model illustrated in the first Albert scenario (See page 9) to one that successfully addressed the complexity of his needs while supporting his quality of life (See page 14).

Although there were other models of care, some that successfully served similar populations and also shared goals similar to the Partnership Program, these models did not have all the elements desired by Partnership designers. The model that most closely approximates the Partnership Program is the PACE (Program for All Inclusive Care for the Elderly) model; two of the Partnership sites were initially PACE programs. However, while the PACE program had several appealing characteristics, The Partnership designers saw a mismatch between PACE and the population they wanted to serve.

The PACE Model

PACE is a nationally recognized health/long-term care model that provides comprehensive, coordinated care to frail older populations. PACE has been shown to be of high technical quality, is highly rated by consumers and providers alike, effectively integrates the care consumers receive across settings such as hospitals and nursing homes, and is cost effective. Therefore, it met several of the criteria that Partnership planners sought for the Partnership Program. Given the similarities between what PACE

offered and what Partnership planners wanted, it is reasonable to question why you might

devote the time and expense necessary to create an entirely new program, or why you

might select a Partnership model rather than a PACE model.

The quick response to this is that the PACE model did not adequately meet the needs of

the long-term care population that the Partnership Program wanted to serve. When

Partnership planners considered the geographic distribution and the age range of

Wisconsin's long-term care population, they felt PACE would be difficult to implement

in the large number of rural areas throughout Wisconsin, and that it was unsuitable for

younger, disabled populations who were also long-term care consumers.

Four specific PACE requirements were of particular concern:

1. **Use of PACE physicians –** The PACE requirement to relinquish one's own
   physician and become a patient of a PACE physician proved undesirable for many
   consumers.

2. **Attendance at adult day care –** Consumers have demonstrated resistance to
   attending a day center on a regular basis (a PACE requirement at the time). This
   can attributed to a variety of things including lengthy transportation time, limited
   interest in group activities especially in rural areas, and varying levels of openness
   to cultural diversity.

3. **Centrality of Physician –** The central role of the physician in care oversight and
   management was counter to the philosophy of a collaborative team approach to
   care that was envisioned by the Partnership planning team. It would also lead to a
   more highly medicalized program than the designers were looking for. The ideal
   program must have a greater balance between health/medical issues and quality of
   life.

4. **Target Population –** The PACE program was designed for frail, older adults with
   limited ability to participate in the community around them. The younger
   disabled population would undoubtedly wish to be more integrated into
   community activities such as work and school.

Use of PACE Physicians

Becoming a patient of the PACE program physician requires PACE enrollees to give up their physicians and their well-established networks of care providers, including supportive home care and personal care providers. Many consumers have long-standing relationships with these providers that have developed over years. The reluctance to give up these relationships is not surprising.

Research conducted by the Partnership research team demonstrated the significance of the physician/patient relationship (as well as relationships with other providers), especially for those with chronic illnesses. Similarly, interviews with a sample of frail older adults from the PACE and Partnership Programs, as well as a sample of similar older adults, demonstrated the importance to consumers of developing and maintaining a trusting relationship with their care providers. It's not only comfort and trust that are enhanced through a lasting patient/provider relationship. Better care outcomes are also achieved (See Appendix E).

Long-term relationships with consumers allow providers to gain important personal and medical knowledge about chronically ill consumers. This knowledge has been shown to increase the effectiveness of care and to make the care more individualized, or consumer-focused. Preserving this important relationship was one of the goals of the Partnership planning team, and one of the reasons a PACE model was rejected.

Attending Adult Day Centers

The PACE model makes efficient use of the day center to deliver a range of services cost effectively. Consumers are brought into the day center multiple days each week to participate in social activities, to receive care from physicians, nurse practitioners, and therapists, to have ongoing and close monitoring of health conditions, and to receive a range of health and social services.

Despite the efficiency of adult day centers, they have never been popular with older consumers. Although some older adults enjoy attending day centers, the majority resist going, preferring to either remain at home or attend activities of their own choosing. Consumers sometimes decide not to enroll in PACE programs, despite the appeal of other benefits, because of their dislike for the day center requirement.

More specifically, consumers felt that transportation to the centers took too long. This was compounded by the time and assistance needed to get up and ready to be transported. Some consumers felt that this was more effort than they were willing to expend,

especially those who weren't particularly fond of groups. Another factor that impacted consumers' willingness to attend adult day centers were a lack of openness to cultural diversity and differences of needs. Some consumers were reluctant to go to centers with people who had physical or cognitive limitations. Additionally, consumers in rural environments were much less likely to want to attend day centers.

As result, the Partnership Program planning team wanted to eliminate the day center attendance requirement because it was not appropriate to consumer preferences. In addition, use of day centers as centralized primary service delivery sites is also much less suitable for programs serving rural populations than it is for those serving inner city or urban groups. In Wisconsin, the likelihood of both rural geography (widely dispersed consumers) and inclement weather made such service centralization unmanageable and unappealing.

Centrality of Physician

Although the PACE program uses an interdisciplinary team to plan and deliver care, the PACE physician plays a central role in most aspects of care planning and evaluation. While this centralization of authority in the physician contributes to the high technical quality of medical care, the model is less conducive to active consumer involvement in planning and evaluating care. A physician-centered model also reduces the extent of care integration across disciplines that can be achieved. Partnership planners were concerned that such a strong physician role would lead to a highly medical model that would not be adequately balanced by other quality of life concerns, or that made adequate use of the other team members' skills.

Target Population

PACE effectively centralizes social, as well as health related activities, providing many of the participants opportunity for social interaction at PACE sites. While this may be acceptable to *some* older adults, younger populations in need of long-term care services, as well as many older adults, are interested in services that will support their active and continuing participation in the larger community, and in activities not organized by PACE. Many non-elderly consumers, in particular, are interested in expanding their social worlds, enrolling in educational programs, and participating in the workforce. For this population, a day center model is clearly inappropriate. The intent to include more than just frail elderly made the less centralized approach, particularly for social activities, a necessity in the Partnership Program. It was also more consistent with a consumer centered model for the elderly since it would allow elderly consumers to determine which activities they wished to participate in, regardless of where they were.

Home and Community Based Services Waivers: Another Approach to Long-term Care

Many states use waiver programs to serve their community based long-term care populations. Other than PACE and the Wisconsin Partnership Program, however, waiver programs involve only Medicaid services. While waivers generally introduce considerable flexibility into the use of Medicaid funds, and they often create some degree of coordination across Medicaid services, they do not integrate Medicare or the services funded by Medicare. As a consequence, most health services fall outside the waivers. This prevents integration (or coordination) of health services *with* long term care services. Workers in waiver programs are often frustrated by lack of access to health care

providers and by the ineffective coordination between health and long term care services and service providers.

Integration of Medicare and Medicaid is the only way to integrate long-term support and residential services and health services into a single system. Many other states and programs have attempted to integrate these care systems while maintaining distinct funding systems. Whether, and to what extent, care can be integrated across these systems without such financial integration is still being debated and discussed. There is, however, little debate over the serious challenges to integrating care when services are funded separately since each funding source has its own eligibility requirements, covered benefits, oversight procedures, associated government offices, and accountability structures.

The most common concerns voiced about complete integration for long-term care populations related to:

- The authority of the medical providers will overwhelm the other providers;

- Too much money will be spent on medical services and not enough on long-term support;

- Compliance will be the only important outcome, and quality of life will take (at best) a secondary position; and

- Institutional, rather than community-based care will become the preferred long-term care option.

These concerns about over medicalization were voiced by long-term support staff who feared that funding integration would simply mean "giving all the money to health care providers." The Partnership planning team was mindful of these issues and of the

challenges that complete integration could create. These concerns were carefully built

into the structure and operations of the Partnership Program. Evaluations of the program

outcomes suggest that:

1. Consumer choice is taken seriously,

2. Institutional placement for this population is reduced (not increased),

3. Quality of life subsumes quality of care, not the reverse, and

4. A Partnership interdisciplinary team (IDT) would oversee all care decisions and would operate as a unit—the medical issues could not 'trump' everything else; extensive discussions were held with staff from health care to design the Partnership team structure that would allow this to happen (see Appendix A and F).

Conclusion

In reviewing the PACE and HCBS waiver approaches to providing long-term care, the

Partnership planners wanted to build on the best elements of these programs by

expanding their concepts and refining their approach to delivering long-term care. The

integrated, consumer-responsive nature of the Partnership model does just this. It would,

however, require a carefully structures mechanism to diffuse authority across the

interdisciplinary team. The suspicion and distrust that already exists between many health

and long-term support providers becomes the focus of a team training program early in

the implementation of the program. The collaboration among team members in

partnership did not "just happen." Developing an effective and highly collaborative

interdisciplinary team requires careful nurturing and support. Each of the Partnership

sites has developed systems to support their teams to this end (Appendix G).

In addition to the more common team development processes, Partnership teams need to develop the ability to become real partners. Staying in silos with careful divisions of labor and authority undermines the ability to integrate, creates redundancy and makes a consumer centered approach very difficult.

Chapter 4
The Partnership Model

Introduction

The Partnership model was designed to build on what had been learned from the PACE model and waiver programs, adapting the Partnership model to address the mismatch between these other programs and the needs of long-term care consumers.

The Partnership Model

The Partnership program is a managed care, fully integrated, consumer centered model of providing care designed for frail elders or persons with physical disabilities (See Appendix H). Key elements of the model include respect, choice, dignity and technical, high quality health and long term care services[1]. Additionally the model promotes creativity and flexibility in problem solving, while remaining cost-effective in delivering care to persons with disabilities, chronic illnesses and challenging life issues. All Medicare and Medicaid covered services including primary, acute and long-term care are included with provision based on assessed need. The goal of the program is to provide quality services that are cost-effective, individualized and congruent with mutually established goals.

A commitment to integrated care was the starting place for the new program. Separation between health and long-term support systems and the discontinuity across service delivery settings and providers guided early discussions about the development of the

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[1] Health services/settings include: home health, hospitalization, outpatient procedures, urgent and emergency care, podiatry, durable medical equipment, nursing home, hospice, medicine, therapies, alternative therapies. Long-term support refers to: social services, personal care, transportation, occupational counseling, nursing home, assisted living, home adaptation.

Partnership model. Because the Partnership target population consists mainly of people who use multiple providers in both health and long-term support systems, effectively managing their care and services would require expertise across these domains, as well as the ability to integrate these networks. The Partnership planning team discarded models that would maintain this separation (waiver programs), deciding on one that would force the integration of care across all these domains. This would be done through the use of integrated funding and interdisciplinary care management teams.

Enrollment in the program is based on eligibility (functional and financial) and is voluntary for the consumer. While the consumer may disenroll and return to the fee-for-service world if they choose, the Partnership organization, except for very rare circumstances, has the member for the duration of his/her life. Each new member enrolls in the program with a primary care provider (PCP). This way, consumers can bring the physician they already have a relationship with. The Partnership interdisciplinary team (described below) works with the PCP and the member to develop a plan of care that suits each consumer.

The core interdisciplinary team, consisting of the member (consumer), the PCP, a Nurse Practitioner (NP), Registered Nurse (RN), Social Worker (SW) and team assistant, is the cornerstone of the Partnership model. The NP is the formal liaison between the team and the PCP. This facilitates close, ongoing communication and assures a single, coordinated approach to care by all providers (the team invites other providers to join them based on member need). A single plan of care is used by all.

Engaging the member in expressing his/her goals and participating in decision-making, guide the team in planning care with a quality of life focus. Social and medical needs are interwoven and thus considered jointly.

The Partnership team provides some care directly, while coordinating through case management, coordinate the care provided by others. The team remains responsible for the overall quality of care the member receives from all providers. Authorization of services, except for high cost and alternative or unique services, is done by the team. The team meets regularly to discuss and problem-solve issues and to plan and evaluate care. Good communication among team members and between the team and other providers is critical to the success of the program. The team interacts with the member and other providers in all settings he/she may access for medical, social or long-term care needs. Being involved in all aspects of care delivery allows for ongoing advocacy by the team and usually provides a deep sense of trust and security for the member.

Management support and guidance to the team is essential for the team to stay focused on the mission and values, stay healthy when dealing with challenging issues and to ensure a standard of practice and service authorization. This important relationship, between management and the team, must be carefully built into the program structure.

Some central features of the Partnership model included:

- Continuing, in most cases, the consumer's physician as primary care provider,

- Structuring the team to promote collaboration and care integration, rather than dividing the labor among provider types,

- Strengthening the role of the consumer in planning and evaluating care,

- Creating a single plan of care and using a single team to coordinate care across systems and settings,

- Using health and long-term support services to improve quality of life.

Implementation Issues Related to Site Considering Partnership

Organizations that have already implemented a PACE model may find that the transition to Partnership is not that difficult. The basic structure, in terms of the provider network, integration of social and medical care, policies and procedures, etc., are likely already in place and just need to be modified to fit the Partnership model. For example, modifications could involve easing restrictions and educating staff on a home-based vs. day-center based model of care.

Organizations that have provided social services and long-term care, but have not provided health care services in particular, may find the transition to the Partnership model more challenging.   For example, there are additional licensing and regulatory issues to be addressed. The financial and physical (including life-threatening) risk of negative consequences, seem overwhelming at first. It is imperative to have an advisor who can help navigate the medical waters, interpret the foreign language and implement preventive plans to avoid untoward legal, financial and human consequences.

Organizations that build from a health care base will face challenges to serious integration of consumer participation and maintaining a focus on quality of life (as opposed to quality of care) as the most important outcome of the Partnership Program. Understanding and appreciating the distinction between technical care quality and quality of life is essential to successfully operating a Partnership Program. Health care providers

and systems will need to work hard to refocus on quality of life. Simply stated, health services (and all other services) are subsumed under quality of life. They are for the purpose of better quality of life rather than an end in themselves. This apparently subtle distinction has a significant impact on how services are planned, implemented and evaluated. While health services remain an essential ingredient in the overall plan, they do not automatically take precedence over everything else. They must earn their way into the plan. Our experience is that most health systems and providers need considerable effort to understand this, and see it reflected in their daily operations.

Goals of the Partnership

To build a program that strengthened the impact and organization of long-term care, one that truly integrated services, planners agreed that the following components would be focal points of the Partnership Program:

- Fully integrating funding streams,

- Developing an organizational structure and care delivery model that promotes full integration and continuity,

- Designing a model built on what is currently known about consumer preference and that has the capacity to respond to consumers,

- Maintaining high standards of professional practice,

- Developing strategies to promote accountability for consumer centered, high quality, integrated care,

- Conducting ongoing, formative research to assist with each of the above.

But what is meant by full integration? Although there are many ways to interpret

"integrated long-term care," the Partnership Program is unique in that it is

comprehensively integrated at *multiple* levels. These levels include:

- **Level 1. Funding streams** - Medicaid, Medicare, and other local sources.

- **Level 2. Networks as systems** – Community-based, long-term support and health care systems.

- **Level 3. Sites and providers** – The PCP, hospitals, assisted living, outpatient clinical, home health, nursing home, DME, therapies, personal care, transportation, etc.

- **Level 4. Consumers and their families** – Through participation in care planning and program evaluation.

Levels 2 through 4 are achieved thru the Partnership team.

Voice of Experience

One level of integration does not guarantee full integration. It takes great care and commitment at all levels to achieve real integration. Lack of attention to all levels will result in re-fragmenting below the level of funding integration.

Full integration requires focused commitment from the Partnership Program management

and staff to function in a truly collaborative interdisciplinary way rather than as several

individuals or organizations functioning autonomously within separate professional

standards, coming together only to keep each other informed, make a referral or respond

to a problem. This is the way integration is often done.

Level 1. Integrated Funding Streams

One of the most important lessons learned in Partnership Program development is that integrated funding is the first step toward integrated care and services, not a guarantee. Funding integration must be followed by an organizational structure and a care delivery model that support and continue integration of services. Medicaid and Medicare are the two largest sources of funding for Partnership Programs. Along with other sources, primarily from local programs, those funds are integrated into a single capitated payment. This capitated payment is what the Partnership program receives regardless of the cost of services provided to the member. Thus, the Partnership program is at "full risk" for expenses over the capitated monthly amount.

Benefits of Integrated Funding

There are a variety of tangible benefits from integrating funding streams. These include increased service flexibility, elimination of cost shifting, and incentives such as better communication and responsiveness and increased payment flexibility.

For individual providers, there is the addition of a team to help coordinate and problem-solve issues with some otherwise very challenging patients and the ability to talk directly with others directly involved with care of the member. The team is designed to work effectively within and across multiple care systems and settings. This is facilitated through contracts that carefully specify Partnership's authority in all settings where Partnership members receive services. Many providers are happy to have a team of professionals to work in collaboration with.

- **Service Flexibility**

Partnership members are not limited to a pre-established list of services designated for a diagnosis or a population. The team is authorized to determine what is needed, and to purchase the necessary services or resources. The challenges of prior authorization are eliminated, which also facilitates a timelier and less bureaucratic process. While many of the alternative services are not made available to everyone in the Partnership program, each interdisciplinary team creates and uses guidelines for unique or alternative services that they deem appropriate and effective in helping the member achieve their goals. For example: warm water exercise classes for elderly members with arthritis have proven to decrease pain and increase flexibility. The social aspect of the classes may also have an impact on depression and isolation.

In approving or authorizing these additional services, it is important for the team to be clear on how the service will address the agreed upon goals, consider all alternatives, and develop outcome criteria upon which the effectiveness of the service will be evaluated. Unlike traditional plans, members are not automatically entitled to services on a "covered" list. Rather, they are determined on an individual basis. Therefore, providing warm water therapy for one member does not automatically make all similar members eligible.

- **Eliminating cost shifting**

  Another benefit of Partnership's integrated funding is that cost shifting between and among various funding streams is eliminated. All available resources are pooled and paid out by the Partnership Program. For example, instead of sending the member to a Nursing Home to avoid paying for home based services, the Partnership organization is financially responsible for these costs in all settings. Thus, using the providers appropriately or creatively to develop alternate plans to meet the member's needs is also in the best interests of the program. A nursing home would not be used to shift costs to another source since the program would still have to provide the services in another setting. This liberates the team from the restrictions associated with most programs and encourages the development of creative solutions.

- **Incentives**

  Individual service providers are not accustomed to working collaboratively across disciplines, even in a single setting. Working collaboratively across settings and networks is even less familiar, and is considerably more challenging. The Partnership Program is structured to provide strong incentives for contracted providers to collaborate with the Partnership team. Without such incentives, service providers are likely to "go their own way." Incentives include providing payments that are more in line with market rates,

providing reasonable payment for services that are not generally reimbursed, and having a contact person at the agency to address problems.

In addition, having access to the Partnership team, and all the resources it can provide, has been a powerful incentive to collaborate. Many contracted providers even accept low reimbursement (or none) for some activities because the team provides such a valuable service.

Voice of Experience

One primary care provider told me it didn't matter whether she was paid for phone calls to the member. Everything she was doing with the member was more likely to work now, and the frustration was so much less, since our team kept her well informed about what was going on at home. Our work saved this provider a lot of time.

The Partnership Program also has the flexibility of providing a higher level of services and rates than those covered by Medicare or Medicaid (more PCW hours/more physical therapy), as well as services that are tied to consumer characteristics such as transportation to a volunteer activity to health with depression or relaxation tapes to address anxiety. This is an important mechanism for responding to the needs of individual members, allowing care plans and services purchased to be better tailored to population and individual needs. Physical therapy, for example, is important to both physical and psychological recovery. Current Medicare and Medicaid limits on who can use this service and how long they can use it prevent care providers from using the services they know

to be beneficial. Some Partnership members may not be able to meet the post hip replacement Medicare outcomes for continuing physical therapy and may be discharged from the Rehab program. The Partnership team may feel that ongoing physical therapy is critical for maintaining function and the ability to live at home and so may elect to approve additional therapy sessions even though typical rehab outcomes may not be achieved.

The Partnership team can also supplement "usual" services. For example, services can be used to supplement hospital or nursing home care, adding important therapies that these environments may not provide adequately. While the first approach is always to convince the contracted provider to provide the high quality of care that is expected, sometimes unique member needs warrant additional services. This might include sending a familiar caregiver to sit with a hospitalized member, to prevent the disorientation that often accompanies hospitalization, or adding physical therapy and more frequent ambulation to keep hospitalized members from losing function.

The Partnership Program tried a supplemental payment to physicians for providing telephone consultation, as physicians are not generally compensated for this service. However, it was found that providing incentives or reimbursement for physicians to set aside time to consult with the NPs was much more useful. This was especially useful when NPs were having difficulties with certain primary physicians with very complex patients/members.

Another strategy used by the Partnership Program is to establish a guaranteed, discounted monthly rate for a set number of services. The WPP purchases a set amount of certain services at a discount and makes them available to members on or off site. For example, the Partnership Program may contract for services, such as physical therapy and dental services, to be delivered at a Partnership site at prescheduled monthly times. One Partnership site contracts with a dentist to provide primary dental care each month at their Partnership site where members can be easily scheduled, transportation can be easily provided, and staff are on site to assist with members whose disabilities make this difficult. Dental Care is difficult to obtain for this population, making this a very effective solution.

Finally, the Partnership Program can increase reimbursement rates for services that are difficult to acquire, making care provision to partnership members more attractive to providers. This is obviously not the first strategy tried, but it is important to have the ability to negotiate when it is really necessary.

Case Examples

The following scenarios highlight Partnership's expanded flexibility in providing services to its members. The ability to respond to each member's needs, to enhance services when needed without hourly caps, and to work collaboratively with providers without worrying about billing or reimbursement processes, makes a notable difference in the quality of members' lives.

Case Example

Nellie was weak and frail from pneumonia and a hospital stay. She needed help with her personal care and rehabilitation to regain her ability to walk and do things for herself again. She really needed to go to a nursing home; however, her last nursing home stay was disastrous. She became depressed, ate poorly, and repeatedly refused therapy. The WPP team decided to try sending her directly home for Rehabilitation. They arranged to have a worker help her get up and ready in the morning and provided intensive, in-home physical therapy until she was well enough to come to the day center for her therapy. Meals on wheels and other housekeeping and personal care services completed the picture. The on-call RN was alerted to the plan and Nellie's support persons should she need assistance during the night. The team was nervous but agreed to give it a try.

The ability to develop a personalized therapy plan for Nellie, one adapted to her needs in her personal living space, was key. She regained enough strength to finish her therapy at the day center where she was able to interact socially with her friends.

Case Example

Al lived at the nursing home for several years but was unhappy with the lack of flexibility and control over his life. Though he was unable to live independently because of the combination of physical and mental health issues, the WPP team moved him to a less restrictive Community Based Residential Facility (CBRF).

This was accomplished by having the WPP physical therapist and occupational therapist and the CBRF staffs do assessments and evaluations in the nursing home. Together they worked on developing an individualized plan to strengthen Al's leg muscles and promote his independence so that he could meet the entrance criteria for the CBRF. The team approved additional therapy hours, which would not have been covered by Medicaid. This gave Al the motivation to cooperate better with the nursing home therapy staff and aides. He moved to the CBRF and is more satisfied with his living arrangement.

Level 2. Network Integration

As discussed above, one of the most problematic issues with traditional long-term care programs is that the services needed by long-term care populations are provided by separate networks: the health care system and the long-term support/social service system. Workers from long-term support programs have ongoing contact with consumers, often making frequent home visits. These workers become familiar with the details of the consumers' daily lives, their family relationships, circumstances that may interfere with their ability to carry out treatment plans. Health care providers are often uninformed about much of this and, as a consequence, may fail to see some of the obstacles to implementing their carefully designed plans of care. Communication between these networks is generally minimal. Information is not freely shared. Each develops a plan of care that may or may not be compatible or consistent with the other. Providers from each of these networks may not even know how to contact the other. This all makes collaboration unlikely and difficult.

While the long-term support and social service systems operate parallel to the network of health care services, there is very little effective collaboration between these networks. This "great divide" causes many problems for long-term care consumers. Consumers in long-term support programs often have a high level of dependency and multiple ongoing needs for both health and supportive social services. These consumers require both a high level of care from supportive home care services and sophisticated, ongoing health care services.

The Partnership model is based on the belief that both high quality health and supportive care are necessary for the target population to maintain the highest level of health and quality of life and to remain engaged in the community as long as possible. The Partnership team has the responsibility for integrating care across these two networks. In fact, the integration of funding used by the Partnership model effectively combines these two networks into a single system, folding all health services with all long-term support services. This integration is replicated at the level of the team which is comprised of staff who represent the disciplines found in both networks (health and social supports). It was quite useful to find team members with experience in each of these networks who could bring an insider's view, established links to providers who would be working with Partnership members, and a commitment to what each network offers.

For example, social workers hired for the teams were generally from long-term support programs with strong commitments to consumer-centered and quality of life. They knew the community and the services provided, and had relationships with other community providers. A social worker with hospital, clinic, or nursing home experience would not be able to male these important contributions to the team.

The nurse practitioners on the team had links to physicians and nurse providers in the community. They had worked with discharge planners, emergency room staff, and clinics and were important for credibility, collaboration, and follow through. The selection of team members who could bring all these strengths to the team became less important over time as the number of teams increased, and the expertise of the teams evolved. New team members hired later in the program can benefit from the experience

of other Partnership staff. In the beginning, these links and experience must be carefully

considered.

Case Example

Claire lived in the same house, with her cousin's family all of her life. She loved children
and was called the neighborhood "nanny" by many because she was always with the
children. She had a developmental disability, no one was quite sure of the specifics.

When Claire's aunt and uncle died, her cousin returned to live with Claire. They had a
wonderful relationship and were very happy in the neighborhood. Then Claire's cousin
developed Alzheimer's disease. The senior center they both attended offered to help find
a worker who could come into their home for housekeeping and some personal care
assistance for Claire's cousin. Claire was uncomfortable with strangers, but her cousin
helped her to accept this new person, Alice, in their lives and in their home. Claire really
liked Alice and would talk to her as Alice went about her work. Things were going really
well until Claire's cousin fell and fractured her hip. Her cousin needed to be cared for in a
nursing home.

The senior center, concerned about Claire, placed a referral to one of the Partnership
programs. After enrollment, the RN and social worker slowly gained Claire's trust by
working with Alice. Alice helped Claire accept these new "strangers" as people who
could help her. Claire's cousin died and the house she knew as home for 83 years had
to be sold.

The team knew they had their work cut out for them to get Claire to even go see an
apartment. This is where Alice was invaluable. She helped convince Claire to at least
see the apartment, then reassured her that she would be coming to help Claire with the
same things she did for her at the house.

Integrating Health Care Providers

Health care providers often have limited information about the daily lives of their patients

and may be unaware of the social circumstances that make it difficult for patients to

follow or benefit from treatment plans. Consequently, health care providers are often

much less helpful then they might be in developing the most appropriate and feasible plan

of care. For example, when diabetics with poor blood glucose control are admitted to

hospitals, they are put on a strict diet and structured regimen that results in normal blood

glucose ranges. Providers can then design a plan for dietary management of the diabetes, based on what worked in the hospital. On returning home, "compliance" often falls apart due to home circumstances inconsistent with those in the hospital. The usual recourse of health care providers is to re-educate and motivate the patient to follow the diet. Having a Partnership team that follows the individual into the home and assesses the health, social and other factors leads to a much more appropriate, and effective, treatment plan.

In addition, the population from which Partnership members come is often seen as "challenging" or "difficult" by health care providers. Their multiple, complex needs and their difficulty navigating service delivery systems create serious challenges to effectively managing their health care. This is often compounded by a lack of information about what is going on at home. Understanding the issues a consumer is dealing with at home can result in a plan that may be less than ideal from a medical perspective but one that can be reasonably followed vs. being discarded at the hospital or clinic door. Partnership Program planners recognized the need to have a well-developed network of health care providers that were set up to understand and meet the needs of this population and open to collaborative partnerships with the long-term care and social service systems.

Integrating Long-Term Support Workers

Long-term support workers often have difficulty obtaining information about the health status and health-related needs of consumers they are serving. Health care providers are often unaware of support networks available or even the ones actually used by consumers for whom they are providing care. Although there may be referrals between these

networks, there is generally little effective collaboration. This undermines care quality

and creates unnecessary work for consumers. It also frequently results in multiple plans

that may be at odds with each other.

Case Example

Mary has been staying home and missing her usual card club meetings and getting more and more depressed and isolated. After repeated visits, the social worker finally learned that she is embarrassed by her urinary urgency and incontinence. The social worker talked to the NP who reviewed Mary's meds, made changes to the dose and timing of her diuretics and started working on other interventions for her urinary urgency. Meanwhile the RN suggested some high absorbency, thin profile pads which wouldn't be so evident with the stylish clothes Mary liked to wear.

Long-term support programs usually respond to functional decline by adding services

such as increased personal care hours, or providing wheelchairs.   The medical problems

that caused (and continue to exacerbate) the functional decline in the first place are

generally left to health care providers. The consumer is left to juggle the sometimes

conflicting interventions of these two well-intentioned groups.

In the Partnership Program, the team coordinates the efforts of each of these providers

and creates a plan of care that all providers contribute to.

Case Example

The following example illustrates the problems that can result when health care systems and social services systems don't communicate.

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<u>Case Example</u>

Mr. Jones was discharged from the hospital on Thursday. The discharge planner met with Mr. Jones on the morning he was discharged. She carefully explained his new medications, the appointments that had been made for his follow up, and made arrangements for a home health nurse to visit once a week. He was given phone numbers to call if he had any questions or problems.

A neighbor took Mr. Jones home that afternoon. He did not want to further inconvenience his neighbor so he said nothing about stopping for medications he needed nor mentioning his need for groceries after being gone from home for so long. He assured his neighbor that there was plenty of food in the kitchen and that he needed no further help.

Mr. Jones did not take his medications. Instead, he took the ones in his medicine cabinet. Most of his food had spoiled, so he ate canned vegetables and soup. By Sunday night, Mr. Jones was in heart failure from his high salt diet and because he was not on the correct dose of diuretics.

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Had Mr. Jones been a Partnership member, he would have benefited from having a single team that crossed systems and was involved in the oversight of his care. The Partnership team would have been involved in the Mr. Jones' hospital admission; they would have participated in discharge planning and stayed in touch with both the attending physician and the inpatient care team.

Partnership would never "hand off" Mr. Jones to another system. His medications would be ordered and provided to him directly, even delivered to his home by Partnership staff or a subcontracting pharmacy, if necessary. Previously prescribed medications would be removed by Partnership staff, minimizing Mr. Jones' confusion about which ones to take.

Groceries or home-delivered meals would be provided until other arrangements could be made.

The Partnership team would have worked out a strategy to stay in touch with Mr. Jones; they would have explained the new treatment plan and made sure it was implemented. The On-Call RN could be notified of Mr. Jones' discharge and any potential problems, along with a plan for early intervention. If problems occurred after hours, the on-call nurse would have access to relevant, up to date information on Mr. Jones.

Partnership research suggests that this cross system arrangement results in more appropriate, timelier interventions and is a great comfort to members of the Partnership Program. Such a system would have dramatically improved Mr. Jones' outcomes. See the next case scenario, below, for an illustration of how Partnership integrates important knowledge about consumers that is often lost along the way. In many systems, such knowledge is not available when decisions are made, leading to unnecessary suffering for consumes. These instances are effectively minimized in a program such as Partnership where knowledge about consumers is highly integrated and accessible. Partnership staff bring important information to each new site and each plan by participating actively in (often directly) care in all settings.

Case Example

Mrs. White was hospitalized when her congestive heart failure became unstable after a high sodium meal with her family. The resident physician at the university teaching hospital wanted to change her medication regime to the state-of-the-art drug he thought she should be taking, and wanted to perform additional testing of her cardiac function. When the NP learned of this on her visit to Mrs. White, she conferred with the PCP and convinced the resident physician to return Mrs. White to her previous medication orders and cancel the tests. The NP explained that the drug had been tried with Mrs. White a few months earlier and the side effects had caused her to become dizzy, suffer injury from a fall, and to not take the medication at home. Further testing of her cardiac function was unnecessary as Mrs. White was in palliative care mode and would refuse any further treatment. This information had been faxed to the hospital upon her admission, but, for some reason, the resident was unaware of it.
The NP also explained to the discharge planner that 24 hours notice would be needed before Mrs. White was discharged so that her twice a day personal care workers could be rescheduled, her medications could be provided in a reminder cassette and her back-up supports could be reactivated.

By the time Mrs. White arrived home, her new medications had been set up, the old ones were gone, and her favorite personal care attendant was waiting for her with her favorite meal almost ready.

Conclusion

While the focus of long-term support is to provide the resources that individual consumers need to remain at home and to assist them in being as independent as possible, it is often the health problems that create dependency in the first place. Consumers who are having difficulty gaining access to health care, who are unable to follow treatment plans for any reason, and who do not have the level of medical monitoring that they need are at risk for becoming increasingly dependent. This close collaboration among providers of health and supportive services is the most effective model.

Level 3. Sites and Providers

Inconsistencies between or among instructions and care plans from multiple providers are not the consumers' problem to figure out. The Partnership Team is responsible for coordinating and resolving inconsistencies. This occurs across sites, providers, and networks. The fragmentation of services that exists in other systems does not exist, or exists to a much lesser degree, in the Partnership Program. The team is able to coordinate and manage all services and systems, provide continuous communication among all providers, and can influence the quality of services provided by others through the contracting process.

The Partnership Team Members

The Partnership team is the heart of the Partnership Program, directly linking care from hospital to home, nursing home to home, hospital to nursing home, and across providers. This is done by:

- Subcontracting with service providers that provide clear links, collaboration and information sharing with the Partnership team,

- Direct contact with Partnership members and through care providers in home, clinic and residential or acute care settings, and

- Using flexible payment mechanisms described above to provide incentives or purchase the most appropriate care.

Experience in the Partnership Program, as well as other long-term care models, suggests that the sort of collaboration required to actually make decisions and design treatment plans in this way is unlikely to be achieved in other less integrated programs. Social workers and supportive service workers do not generally have access to or influence on the design of health care treatment plans. Even when social workers sit on

interdisciplinary teams they are often in charge of only those things in the social services domain and do not become actively involved in health treatment decisions or priority setting. On the other hand, health care workers are often unaware of the interplay between treatments and other activities in the consumer's life even though they may attempt to factor these considerations into their treatment decisions. One reason is that consumers do not often share such things with health care providers even when they are asked. Most consumers, especially older adults, minimize the impact of illness and treatment on the quality of their lives or believe nothing can be done anyway.

> ### *Voice of Experience*
>
> **Though there has been no actual study of the staff turnover or satisfaction, interviews suggest that working in a Partnership Program has many benefits for all levels of staff. Interdisciplinary team staff commented on wanting this to be their last job. Others said that practicing in this model is consistent with how they were educated and fits with their values. Individuals in management positions attribute a lot of the satisfaction to the lack of a hierarchical structure and to staff being able to make timely decisions regarding allocation of services.**

The quality of both long-term care and health services is greatly improved through the interdisciplinary team model of the Partnership Program. Consumers in the Partnership Program have fewer providers with whom to negotiate, or provide information to, and receive fewer redundant assessments. Having a care management team that directly and routinely interacts and negotiates with all of the service providers saves consumer's work. Consumers do not have to repeat medical histories, recount or explain services used or preferred as they encounter each new provider. Much of this work is done for them by the Partnership Team.

Team members include: a nurse practitioner, who also represents the PCP's perspective, a social worker or social services coordinator, a home care nurse, a team assistant or coordinator, and the member. The team is not only the human face of the program to the member but also the vital link to the provider network to ensure program values are present regardless of the provider of service (See Appendix I).

- **Nurse Practitioner**

  The nurse practitioner is responsible for overseeing the health status and health care for members including health maintenance activities and management of acute and chronic medical conditions. The NP is also the primary liaison between the team and the members' physician. The physician is, therefore, integrated into the team through the nurse practitioner. Nurse practitioners in the Partnership Program put a great deal of effort into developing and maintaining this relationship, keeping effective communication flowing. The NP and the primary care physician (PCP) discuss the type, amount and timing of information to be shared, the problems which the NP will handle and which issues require consultation with the PCP.

  The NP is also the liaison to hospitals and nursing homes, taking major responsibility for transitions into and out of these settings, and for monitoring the standards of care received by members.

- **Social Worker**

  The social worker brings long-term support experience as well as a link to the local long-term support network. Knowledge of support services available in the community, familiarity with providers of these services, and an appreciation for managing care at home are the most important elements brought by the social worker. The social worker's expertise in combination with the nurse practitioner's skill at managing serious illness and working with the primary care physician, can be more effective in keeping members with serious illnesses and complicated needs in their homes. Social workers in the Partnership program have ongoing access to health care information and develops insights into how illness is managed. Nurse practitioners develop insights into how supportive services can be used to prevent further declines and promote greater quality of life. This makes each more effective, and makes both better team players.

- **Registered Nurse**

  The home care nurse, also a member of the Partnership Team, is able to closely monitor the health status of members and provide in-home nursing care. A major advantage the home care nurse brings to care management is the ability to respond quickly to changing member needs related to illness or injury. By increasing, decreasing, or altering health care services, sometimes a move to a rehabilitation or convalescent center can be prevented. The direct working relationships the RN has with the social worker and nurse practitioner can minimize communication problems so common in other

systems, and encourage information sharing. In addition, links (through the nurse practitioner) to the primary care physician result in a single coordinated plan of care, rather than multiple plans that may be inconsistent with each other.

- **Team Assistant/Coordinator**

  As the Partnership programs grew in size, managers realized that the team members were getting bogged down with clerical and scheduling activities which limited time spent in direct contact with members or in interdisciplinary dialogue and care planning. The role of team assistant, sometimes called service coordinator was developed. This position was responsible for triaging phone calls, scheduling appointments, faxing and mailing, entering data in the system, and being of general service to the team. This role became an important factor in team efficiency and staff satisfaction.

Level 4. Integration of Consumers and Consumer Centered Care

The Partnership Program designers were committed to providing consumer centered care. This was not something that would be added to the care plan or that would be the responsibility of any single team member or discipline. The designers believed that the only reliable way to achieve "consumer-centeredness" was to build it into every aspect of the program and organization, from the design of information systems and quality improvement processes to the development of job descriptions, recruitment and selection

of every staff member, funding mechanisms, contracts with other providers, policies and procedures, and the overall structure of the organization.

The first challenge was to determine what makes care consumer centered, and how such care is distinguished from care that is not consumer-centered. As is true with integrated care, references to "consumer centered care" are so pervasive and are used to describe such diverse models of care that it has become a relatively meaningless term. In fact, it would be difficult to find any health or long-term care program that did not claim to be providing consumer centered care regardless of the model being used. It was important for program designers to clarify just what it was they meant by consumer centered care and how it would be supported by the Partnership model.

To accomplish this, several early decisions were made. First, a major research project was conducted to determine what was important to long-term care consumers (See Appendix J). Second, ongoing participation from consumers would be sought in both planning and evaluating care and service quality in the Partnership Program. Third, published research on consumer preferences was used to guide the initial program design. Fourth, high technical standards of care would be maintained within the Partnership Program, as well as with subcontracted services. Each of these strategies is discussed below.

The Quality Research

As part of the original grant from The Robert Wood Johnson Foundation, an intensive, ongoing field research program was built into the design of the Partnership Program Demonstration. One purpose of the research was to learn from consumers in the Partnership Program how to design and deliver consumer centered care. Consumers enrolled in the Partnership Program during the first 3 years of operation were interviewed by the research team to learn what they viewed as the most important quality of life issues, what challenges, complaints or difficulties they were having with any of the services, what they would like that they were not getting, and their general evaluation of the program, services and providers.

In total, 76 interviews were conducted with frail older adults, younger adults with disabilities and their caregivers. The research was used to develop a consumer evaluation on quality of care in Partnership (Appendix K), a set of quality improvement protocols (Appendix L) and a set of criteria that could be used to guide and evaluate care and

services (Appendix M). Thus, the definition of consumer centered care and a consumer-centered program developed as the Partnership Program evolved. Much of what is now done to facilitate consumer centered care is based on this research. Indicators that can be used to evaluate the achievement of consumer-centered care were developed during the three-year demonstration with the input from consumers, family members, Partnership staff, and other providers.

As part of the Partnership organization's contract requirements with the state, each organization is required to conduct an annual consumer satisfaction survey. While the usefulness of the rating scales are subject to debate, often the subjective feedback provides insight into consumer feelings about the program. One of the resounding themes that emerges is the consumer appreciation for the personal attention and caring of the staff. Comments like "they really know me", "they take the time to listen" and "really care" seem to reinforce that care in the Wisconsin Partnership Program is consumer-centered.

Each of the agencies also pick two topics annually on which they conduct a focus study. These studies have included areas seen as problematic or new programs to be evaluated and included topics such as chronic pain control, end-of-life care, CBRF quality, falls and medication use as examples (See Appendix N).

The following case exemplifies the importance of involving consumers in decision making by getting to know what their goals are. In this scenario, the team helps the consumer continue an important tradition by helping her make decisions about her care, and manage her health while accepting more services and support.

Case Example

Mabel was frail now at 90 and lived with her son-in-law and only daughter Mary. She still had unresolved grief and guilt over her husband's death 15 years ago. She struggled with depression in addition to osteoarthritis and hypertension, and now they thought she might have a recurrence of her bowel cancer because she was losing weight. She didn't want to go through the surgery again like she had before. The only thing which she had to look forward to was the month she spent every summer with her daughter and son-in-law at the cabin up at the lake. How she loved that. It brought back memories of when she and her husband and Mary would spend summers at the cabin.

The team appreciated and supported Mabel's goal. The problem was that she was very frail, wasn't eating well and often forgot her medications. However, she was a very proud woman and stated that her memory was "just fine." The team talked with her about how she could best prepare to make the trip to the cabin by eating her home-delivered meals and supplementing with a can of Ensure. The RN convinced her that it would be easier to get her medications delivered in a cassette and that many of the program participants get their meds that way. The NP and social worker talked about her choice in having a work-up to check for recurrence of the bowel cancer and what her options were. She elected to not do anything at this time because she felt well and wouldn't agree to have surgery anyway. Planning for and taking the trip the following summer was the goal. To achieve this she needed better nutrition, careful medication management and enough physical therapy to build her strength.

Organizing her care plan around her goal provided direction and motivation. It helped the team maintain focus on strategies to reach her goal, not interventions for their own sake or simply to meet case standards. Subsuming case interventions under the consumer's goals keeps technical quality high while maximizing consumer quality of life.

Consumers who took part in the Quality Research initiative confirmed repeatedly that their relationships with care providers were the most important components of care quality. For the younger Partnership consumers, having a trusting and comfortable relationship with physicians and Partnership team members meant several things. It meant that providers: were familiar with them as individuals, were aware of the

idiosyncrasies of their health situations; trusted consumers interpretations of bodily cues; and responded quickly to consumer requests. For older consumers a good relationship with their providers meant that the providers knew their personal and health histories, understood how these histories influenced each other, adapted care decisions to fit what was most important to individual consumers, and were able to deploy and supervise (or subcontract with) other service providers to ensure that care was provided as the consumer preferred. Relationship quality and continuity became central quality criteria for the Partnership Programs as the mechanism to increase quality not an end in itself (Appendix O).

The Partnership research also revealed that medication side effects were one of the most significant quality of life issues for consumers. Most consumers interviewed for the study described altering drug regimens, stopping medications altogether, altering dosages at some time prior to enrolling in the Partnership Program. Several stated that they were reluctant to tell physicians about their objections to the medications and simply adjusted them on their own. This often led to serious consequences for consumers.

Acknowledging the importance of side effects and their impact on quality of life, Partnership providers are careful to discuss this with consumers. In this way, consumers who cannot tolerate particular side effects may be offered an alternative, one with fewer or different side effects. What is different about this is the recognition of how important quality of life is and how important side effects are for quality of life. Rather than simply insisting that drug A is the only reasonable drug to take, Partnership providers acknowledge that such approaches often simply discourage consumers from being

honest. Also, recognizing these difficulties, avoiding judgments, and listening carefully

to consumers creates a more collaborative relationship between consumer and provider.

Consequently, while drug efficacy is the central consideration in prescribing, quality of

life is also important and member choice are also important. There are several possible

medications that can be used for high blood pressure. Some leave the member nauseous,

some leave the consumer fatigued, and some impair memory. Most members would like

the chance to have input into which of these they will be subjected to. Some members opt

for less aggressive treatment after a discussion about the trade offs between practice

standards and quality of life.

Case Example

The only really important social activity left for Mary was her bridge game on Tuesday. She saw women from her old neighborhood and really enjoyed the game as well. The trouble was Mary might be incontinent if she took her medications on Tuesday morning. So Mary took the pills from Wednesday through Sunday. She stopped on Monday and Tuesday. This solved her incontinence problem. Unfortunately, she had many hospitalizations for heart failure during the year. Her physician asked her if she was taking her medications. Mary was embarrassed and didn't want to admit what she was doing, so she did not tell her doctor.

The team worked with Mary to keep her out of the hospital. Through their discussions with Mary, they learned what she was doing. A decision was made that Mary would take a lower dose of her diuretic on Monday and would take it later in the day on Tuesday. This controlled the incontinence enough to play bridge and reduced her admissions to the hospital. The drug regime was not ideal, but it was considerably better than what Mary had been doing on her own. This plan also established a level of trust, encouraging Mary to be more forthcoming with her team in the future.

For younger disabled consumers, reducing the work they must do on a daily basis to

facilitate their own care is a central quality issue. This work includes such things as:

- Filling out insurance forms,

- Managing cumbersome office visits,

- Scheduling, and rescheduling, transportation,

- Adopting to and accommodating PCW schedules,

- Supervising PCWs,

- Arguing with health care systems and providers to acquire what they need,

- Finding support to engage in social, educational and work activities, and

- Creating back up personal care systems.

The Partnership Program sites developed several policies and practices in response to these issues. One example is a checklist that was developed from consumer interviews to evaluate the accessibility of clinics and offices used by Partnership consumers. The checklist included: wait times, bathroom accessibility, exam tables, likelihood of getting out on time for scheduled transportation, lab accessibility, entrance doors, receptionist sensitivity, provider sensitivity and responsiveness. Consumers were asked to rate their visits and providers were given the results. Many changes were made in clinics and offices as a result.

Partnership Programs also purchased their own vans and hired drivers to accommodate the difficulties most consumers had with transportation services. This led to much greater flexibility and the opportunity to respond to individual consumer needs. While expensive, this was considered vital to facilitating flexibility and consumer choice. Services that are highly contested in other programs, such as ongoing physical therapy, nonpharmacological pain management, dietary supplements and massage are individually

tailored to Partnership consumers. In many instances, consumers opt for less expensive

treatments than those that are available in more mainstream programs.

Case Example

An older woman used a tape player with earphones to listen to relaxing music. This was her preference over anti-anxiety medications. The tape player was $10, and the tape $5. This led to better, less costly results than medications and certainly created fewer side effects.

Active Participation from Consumers to Plan and Evaluate Care

The Partnership model supports and encourages the involvement of consumers in

identifying treatment goals, *not just how the goals identified by providers will be*

achieved. Assessment and treatment plans are designed to assist members to achieve the

goals that are most important to *them*, as well as to promote high standards of care. Thus

consumer 'expertise' is combined with the wisdom and expertise brought by the care

management team and other providers. Understanding what the consumer wants and what

his/her life goals are may change a decision for surgery or chemotherapy. This is in sharp

contrast to what occurs when supportive services are separated from health services. In

this latter instance, health services are designed to promote high standards of practice and

are illness focused, while supportive services are focused on quality of life and on living

with the consequences of illness. The plans established in each of these two domains are

often at odds, or at least are rarely complimentary. The consumer is then left with the

burden of bringing these systems and treatment plans together or choosing between them.

Involving consumers in developing the plan of care, and identifying the goals to be

achieved, is vital. This is fundamentally different than what is generally done in health

care settings where patients are invited to participate in determining *how* a goal is achieved but not *what* the goal is to be. This shift realigns care plans to support whatever is important to the consumer.

For example, increasing personal care services and ordering adaptive aids for the home might be pursued in a program focusing on supportive services. Without a health care professional involved in the discussions about declining functional ability, there might not be testing to see if a medical cause might be present. It might be something like low potassium levels, urinary infection, or side effects of medications or anemia, which could be easily treated. On the other hand, treating medical problems without regard for the home situation and quality of life issues can have serious negative effects (see case example of Mr. Jones page 46). The integration of health care providers and approaches resulting from having the team act as care manager also leads to more consumer centered care.

Consumers who suffer from constant pain, nausea, or fatigue often are unmotivated to engage in activities that would be satisfying if they were free from these symptoms. Family events, volunteer work, visiting with friends are much less enjoyable when in pain. Partnership members generally have multiple illnesses and require treatments that often have side effects. Understanding that it is the pain, the nausea, or the fatigue that is preventing satisfying social engagement helps the team develop a care plan that can bring health care services to bear on quality of life only if the team understands the relationships among them. Otherwise a health care provider focused on providing state of the art health care may undermine quality of life by treating a health problem

appropriately while leaving the consumer with other side effects that undermine quality of life. A social worker focusing on the cherished activities that are precluded because of the constant fatigue can influence the selection of medications, the intensity of treatments, so that fatigue is a less likely or less intense side effect. The following example illustrates the importance of the Partnership Team approach.

Case Example

Isabel and her husband, John, had been married for 65 years. She had always managed the household and been the social link for John. While John was more simple in his interactions, he was Isabel's strongest supporter which led to a strong, balanced relationship. As Isabel and John became more frail, they moved in with their daughter and her family. Isabel's macular degeneration left her legally blind. She also exhibited some mental health problems, including paranoia. Isabel accused her daughter and granddaughter of stealing from her and wanted John to say he believed her 100%. John wanted to support Isabel as he always had, but felt caught in between his wife on one hand and his daughter and granddaughter on the other. Plus he didn't believe they would steal from Isabel. The physician's decision was to treat Isabel's paranoia with an anti-psychotic medication. One month later, Isabel developed frequent diarrhea, a flat affect and bradykinesia (extreme slowness of movement), which caused her to not make it to the bathroom in time.

She stopped going out anywhere, even to church. The GI physician with whom they consulted wanted her to have a colonoscopy right away. Concerned that Isabel might be having a recurrence of a past colon cancer, and anxious about feeling like he needed to make decisions, John agreed. The Partnership team discussed the situation and the issues around Isabel's quality of life. They felt that the diarrhea was related to the medication and wanted to wait for the dose adjustment before rushing to more testing. The anti-psychotic medication was decreased and her anxiety was treated. The diarrhea improved and while Isabel still had paranoia, she was able to cope with it better and wasn't crying all the time. Since it was so difficult for Isabel to deal with any change, the team planned to talk with her about her wishes and what she would wish to do if something critical was found on the colonoscopy. Isabel's physical ability to handle surgery and rehab if needed was very questionable. At age 87, and with her mental and physical health challenges, the colonoscopy might not be the best course to pursue right away. The bowel prep alone could be overwhelming.

The team planned to discuss the problem, options for treatment and timing of interventions with Isabel alone, first, and then with her and her husband John. The NP collaborated with the PCP on this plan. Considering the impact of diagnostic studies and treatment consequences on quality of life often leads to slowing down the testing process or deciding to live with the risk of untreated disease. Taking the time to allow the consumer to be fully informed and involved in the decision-making is critical.

Using Published Research To Guide Program Design

Another strategy used by the Partnership Program to create a consumer-centered system

is the use of published research and advocacy groups to guide program development.

Research and other available information related to consumer experiences were used to

develop initial care plans. For example, research has confirmed that younger disabled

consumers, in general, do not receive adequate primary care. Primary care providers tend

to focus on the disability, leaving the routine screening and prevention unattended to.[2]

Consequently, a special effort was made to ensure that these preventive procedures were

done as appropriate. This became a responsibility of the team and was reflected in its

own actions as well as how they influenced other care providers.

Another example of how the research literature was used to guide program design is the

creation of medication monitoring systems to prevent medication errors. There is a well-

documented high incidence of medication errors made by frail older adults. These errors

lead to almost half the annual hospitalizations of older adults in the US, and lead to much

unnecessary suffering. In response to this, information systems were put in place to

review and closely monitor current medications, changes in prescriptions, including

dosages and the potential for drug/drug interactions. Negative consequences from

medication errors were minimized.

The Partnership structure makes this possible since all providers are in such close

communication with one another. Research on both hospitals and nursing homes has also

documented the usual decline in physical functioning experienced by many elderly after

even short stays. Informed by this research, the Partnership team closely monitors

members in these environments, to ensure that adequate preventive measures are being taken by the staff. These expectations are also built into Partnership contracts with hospitals and nursing homes. The Partnership team, first of all, tries to prevent unnecessary hospitalizations and to ensure that the length of stay is no longer or shorter than necessary. This is accomplished by being clear on the goal of hospitalization, how it affects overall consumer goals and any unique circumstances related to discharge. High intensity home care can be used during an acute illness to prevent hospitalization. Timely and accurate information sharing and advocacy is critical. The Partnership NP also ensures that appropriate physical therapy and ambulation are instituted to prevent decline from inactivity while in more sedentary situations.

Maintaining High Technical Standards of Care

Another strategy to build a consumer centered system is to provide high technical quality care. This means that is it vital to have a medical director who is a well respected, highly regarded practitioner in the community, whose work is visible to other community providers, who has expertise relevant to the population served and who actively pursues continuing education. The Partnership medical director is a resource to both primary care providers of the members, and to the Partnership teams and raising the standards of care across settings. Care is carefully monitored. The team or WPP physician intervenes when necessary to raise care standards. This effectively brings expertise on geriatrics or disabilities to PCPs without such expertise.

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[2] DeJong, G. (1997) Primary care for persons with disabilities: an overview of the problem, *American Journal of Physical Medicine and Rehabilitation*, 76 (3), Suppl., pp S2-S8.

The medical director is a vital link to the physician provider panel. She/he can help the physicians and NPs better understand each other's practices and suggest strategies for the NPs to work most effectively with the physicians. The medical director has more "clout" with the physicians and can help problem solve difficult relationships. One of the Partnership sites found it to be very worthwhile for the medical director and program manager to meet with each new physician who joins the provider panel, to explain the philosophy and expectations of the program, standards of practice, and role and abilities of the NP. The medical director is also a resource to the NPs regarding current medical practice and utilization review. Experience has shown that preventive measures are more effective and easier than trying to correct problems.

A Partnership program must also be committed to, and actively involved in, evaluating and acquiring skills that they do not have. In Partnership, such skills have included AODA, mental health assessment, counseling, and hospice care.

Conclusion

Overall, the Wisconsin Partnership Program is designed to maximize continuity, coordination and consistency of services. Important information about consumers is brought forward into new encounters, diminishing the need for consumers to keep telling providers the same stories. Providers have quicker access to the information they need, reducing time needed to 'figure out' what is going on, and more importantly, maximizing the occurrence of integrated, consumer centered outcomes.

Chapter 5
Outcomes of the
Partnership Program

Introduction

The effectiveness of the Wisconsin Partnership Program has been demonstrated in a variety of ways. From its built-in savings to Wisconsin's Medicaid program and its reduction of institutionalization and hospitalization rates, to high consumer and provider satisfaction, promising outcome results, and innovative quality improvement projects, the Partnership Programs successfully provide high quality, consumer-centered, cost effective services.[3]

Built-in Savings

Medicaid managed care programs are required to be "budget neutral." As such, payment to managed care organizations such as the Partnership Program cannot exceed what the state projects it would have paid for services for the same population, over the same period of time, under a fee for service system. To achieve some savings in its managed care programs over what it would have spent in fee-for-service programs, the state of Wisconsin has built in a 5% "discount" from the determined reimbursement rate before payment is made to the Partnership Programs. This feature does two important things: it guarantees savings and puts all the risk on the managed care programs.

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[3] The information contained in this chapter was excerpted with permission from the WI Department of Health and Family Services' (DHFS) Partnership Waiver Renewal, Section 6-IV: Assessment Demonstration.

Reduction of Institutionalization and Hospitalization Rates

Wisconsin's Department of Health and Family Services (DHFS) analyzed utilization in the Partnership Program by tracking the utilization of members pre- and post-enrollment. Staff identified 227 Partnership members who had been enrolled in Partnership for at least 6 months and who had at least 18 months of Medicaid fee-for-service experience prior to enrollment.

Table 1 compares hospital, emergency room, and nursing home utilization for those 227 people before and after enrollment, reflecting a steady increase in hospital and nursing home utilization by these individuals prior to enrollment in Partnership.

Table 1.

Partnership Program Reduces the Use of Hospitals and Nursing Homes

	Year 3 Prior Partnership Enrollment	Year 2 Prior Partnership Enrollment	Year 1 Prior Partnership Enrollment	Year 1 After Partnership Enrollment	Year 2 After Partnership Enrollment (Annualized)
# Eligible Months	**2,144**	**2,606**	**2,698**	**2,374**	**1,201**
# of FTE People	**179**	**217**	**225**	**198**	**100**
Hospital Days Per 1000 People Per Year	**1,718**	**2,321**	**3,430**	**3,070**	**2,958**
Nursing Home Days Per 1000 People Per Year	**1,730**	**4,047**	**9,435**	**4,322**	**8,273 5,367***
ER Visits Per 1000 People Per Year	**465**	**1,064**	**965**	**940**	**739**

*One individual was in a nursing home the entire 14 months prior to her death. The "5,367" excludes her.

While some increased utilization can be attributed to the effects of aging and the progression of chronic conditions, in three years prior to enrollment in Partnership,

hospital days per 1,000 people per year almost doubled and nursing home days more than tripled.

The final two columns of Table 1 display data for the 227 individuals post enrollment in Partnership. The hospital days per 1,000 people per year dropped by 10% in the first year, and another 4% in the second year, as opposed to what would be expected which is an increase in these days. Additionally, there was a dramatic reduction of nursing home days used during the first year post Partnership enrollment. For example, 48 of the 227 people in this study were in a nursing home during this 5-year period. Nine of the 48 people exceeded 90 days of nursing home care in the year prior to Partnership enrollment. Those nine people received 1,736 days of nursing home care in the year prior to joining Partnership, while receiving only 12 days of nursing home care in the year following Partnership enrollment.

Graph 1 illustrates the trend of hospital utilization in the fee-for-service system of these 227 individuals prior to enrollment in Partnership. The two points below and to the right of the trend line (in red) reflect actual experience after enrollment.

Graph 1.

**Comparison of Hospital Days Used Per 1000 People Per Year,
Before & After Partnership Enrollment**
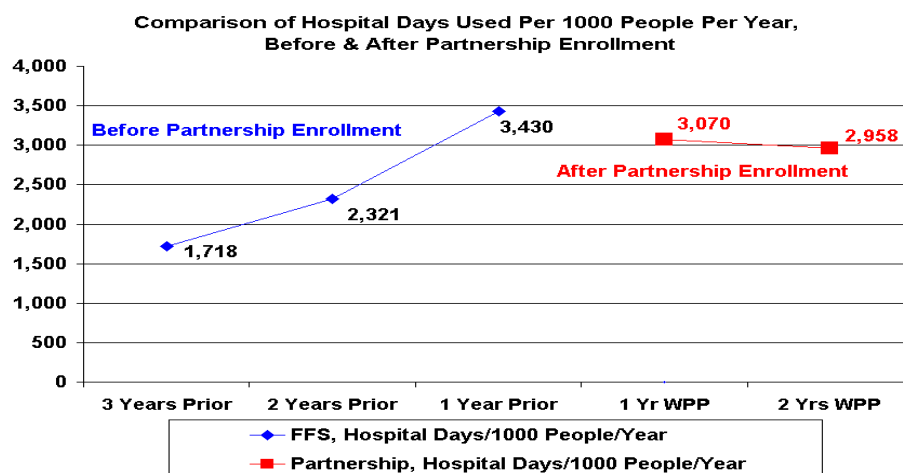
Graph 1 illustrates the impact that the Partnership program has had on inpatient hospitalization. The first three data points show a rapidly increasing rate of hospital utilization in the baseline period (i.e., pre-Partnership enrollment) for the study population. Subsequent to Partnership enrollment, the rate of hospital utilization drops off dramatically. Not only is the absolute level of hospital utilization lower after Partnership enrollment, but also the trend over time has flipped from a sharp increase to an actual downturn in hospital utilization. Given the population being served, this is an unexpected accomplishment.

Similarly, Graph 2 (see below) demonstrates the large reduction in nursing home utilization that the Partnership program has been able to achieve. The first three data points show a rapid increase in the rate of nursing home utilization in the baseline period for the study population. Subsequent to Partnership enrollment, the rate of nursing home utilization drops off dramatically. That is, the absolute level of hospital utilization lowers considerably after Partnership enrollment. The increasing trend has also been reduced

from the baseline period, although not as dramatically as for hospital utilization, where the trend was reversed.

Graph 2.

Comparison of Nursing Home Days Used Per1000 People Per Year, Before & After Partnership Enrollment, Outlier Included
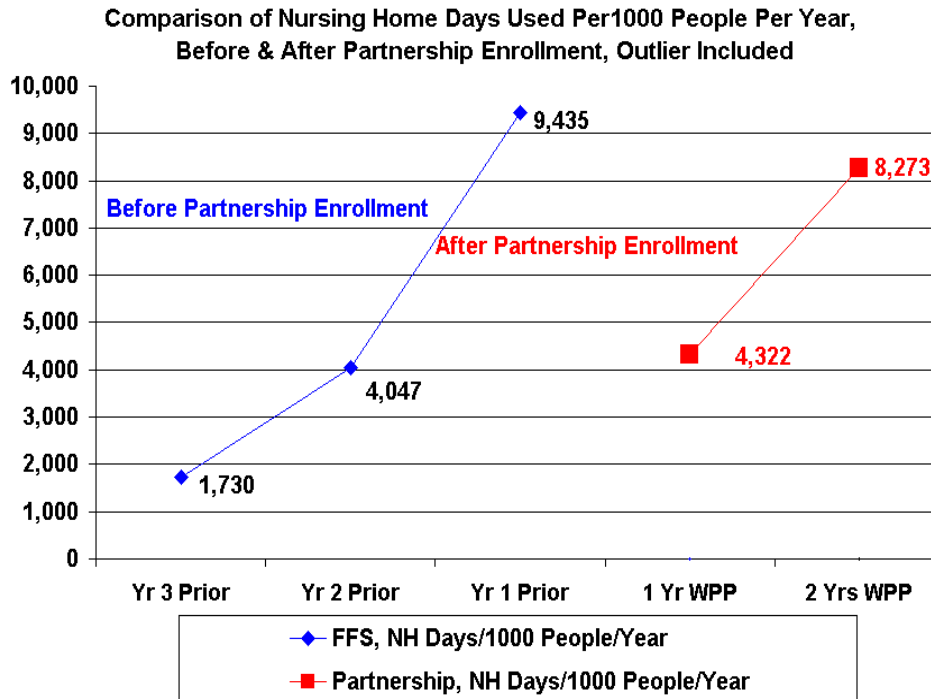
Also note that nursing home use increased significantly during the second year after Partnership enrollment largely because one person resided there for 14 months prior to her death. At this time, there is insufficient longitudinal data at this time to project nursing home use by members after enrollment in the Partnership Program.

Graph 3 also illustrates the trend of nursing home utilization in fee-for-service system prior to enrollment in the Partnership Program but excludes the outlier identified in Table 1.

Graph 3.

Comparison of Nursing Home Days Used Per1000 People Per Year, Before & After Partnership Enrollment, Outlier Excluded
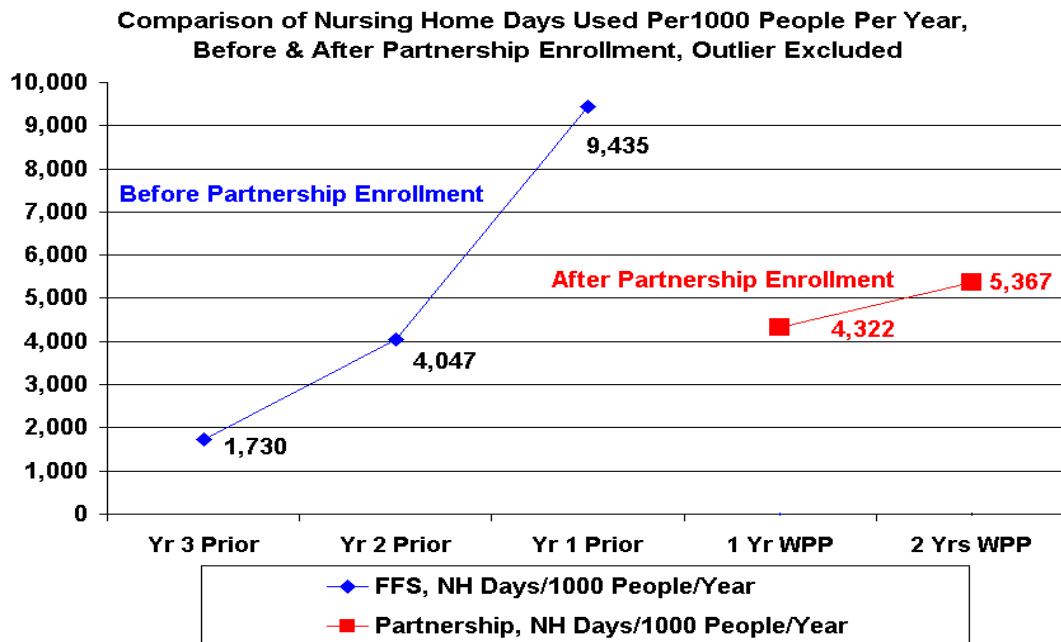
Though the Partnership Program is relatively new, this initial data demonstrates a notable reduction in hospital and nursing home days used. Partnership members have experienced fewer hospitalizations and nursing home placements than they had previously in the fee-for-services system. They have also experienced a reduced rate of hospitalization and emergency department visits for ambulatory care sensitive conditions (ACSCs). This reduced utilization is the result of better care coordination and, by implication, improved access to preventive care.

Consumer Satisfaction and Outcomes

A variety of consumer surveys and interviews have been conducted with Partnership members. Two of these are the Kane Survey[4] and the Council on Quality Leadership's (CQL) consumer outcome interviews. Each of these, discussed below, concluded that members of the Partnership Program, as well as participating providers, were satisfied with the program.

Kane Survey

The Centers for Medicare and Medicaid Services (CMS) contracted with Dr. Robert Kane, MD (University of Minnesota, Health Services Research and Policy School of Public Health) in the first half of 2000 to survey Partnership participants and family members and assess the utilization and quality of care from claims data. The Kane survey was designed to obtain demographic and health status information about participants and also to elicit satisfaction ratings about a wide range of services from both Partnership members and family members. Kane's survey was conducted with two comparison groups—participants in the Milwaukee PACE Program and participants in Wisconsin's 1915(c), COP-Waiver Program. Overall, levels of *satisfaction with care* were the same for all survey respondents across all three groups. However, in general, family members of Partnership members tended to express somewhat more satisfaction with the Partnership Program than with the other two programs.

Findings from both the Kane Survey and CQL's outcome interviews (see Table 2 and 3 below) also indicated that participants, both elderly and disabled in all three programs,

were highly satisfied with access to care. This finding was important to both DHFS and

CMS since both were interested in whether Partnership organizations could create large

enough networks to offer their membership sufficient access and choice among providers.

Table 2.

Access to Care
WPP versus PACE and COP-W
Elderly Participants

Item	WPP %	PACE %	COP-W %
Receive services when needed.	95	94	92
Your doctor or other health professional responds quickly when you get sick.	94	96	93
Your doctor will hospitalize you when your health problems require it.	98	99	97
You can see a specialist whenever you need to.	92	94	95

Table 3.

Access to Care
WPP versus PACE and COP-W
Participants with Disabilities

Item	WPP %	PACE %	COP-W %
Receive services when needed.	90	NA*	85
Your doctor or other health professional responds quickly when you get sick.	94	NA	92
Your doctor will hospitalize you when your health problems require it.	96	NA	94
You can see a specialist whenever you need to.	94	NA	93

* People with disabilities are not eligible for PACE

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[4] Kane, Robert L. Multi-state Evaluation of Dual Eligibles Demonstration: Third Annual Report (April, 2002).

Because Partnership plans are capitated for both Medicare and Medicaid, they are able to provide services to beneficiaries that would not ordinarily be available to regular Medicare or Medicaid beneficiaries. An example is the dental services being provided to members of the two Partnership plans in Madison. Medicare does not normally cover dental services. While Medicaid provides dental coverage, very few dentists in Wisconsin have elected to participate in the program with the result that access to dental care is limited for Medicaid beneficiaries. One program negotiated an agreement with the Marquette University School of Dentistry. The School of Dentistry provides services to members in a dental office located at one of the Partnership Sites. The plans feel that the provision of these services is cost-effective and it reduces the incidence of potentially more expensive oral health and other medical problems that would result from inadequate dental care. In a recent informal study it was determined that approximately 17% of Partnership eligible people in the Medicaid fee-for-service system received dental services in 2001. By comparison, approximately 70% of all Partnership members received dental services in 2001.[5]

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[5] It is important to note that not all findings of the Kane report were positive, particularly those related to the cost of the Interdisciplinary Team (IDT), the usefulness of the nurse practitioner (NP) role, and the effectiveness of the program in changing behaviors of physicians in the community. Acknowledging these concerns, Partnership staff felt that the study was conducted too early in the development of the Partnership Programs and did not reflect Partnership Programs that were up and running. The study, as a result, reflects on programmatic elements that were still under development.

> ### *Voice of Experience*
>
> **Capturing accurate and useful data about your Partnership program is critical regardless of the stage of program adoption. Make sure you know what data you want *and* need to collect and establish reliable mechanisms to gather this information accurately and early in the development and implementation process.**

Council on Quality and Leadership

DHFS also contracted with the Council on Quality and Leadership (CQL) to survey 140 randomly selected participants in the Partnership Program. The survey was performed in March and April of 2001. The CQL survey was selected, in part, because it stresses the assessment of plans in terms of member defined outcomes.[6] Samples of the results for two outcomes (*People Have Best Possible Health* and *People Choose their Services*) are illustrated in Graphs 4 and 5 (see page 77 & 78). Consumer satisfaction is detailed in Graph 6 (see page 79).   Member outcomes are not only indicators of satisfaction with services, but also as outcomes generated by the services being provided.

Graph 4 indicates that more than 80% of the Partnership consumers interviewed reported achieving the outcome *People Have Best Possible Health*. Graph 5 indicates that roughly 65% of Partnership consumers interviewed reported achieving the outcome *People Choose their Services*. Finally, Partnership consumers reported that Partnership services met their expectations and needs 74.3% of the time, as depicted in Graph 6. Though the Department would like to see a level of satisfaction from Partnership members approaching 100%, it views these initial results as a significant achievement.

Graph 4.

Member Outcome Results for: "People Have the Best Possible Health" Family Care (FC), Partnership (WPP), PACE, and Home & Community-Based Svcs. Waivers

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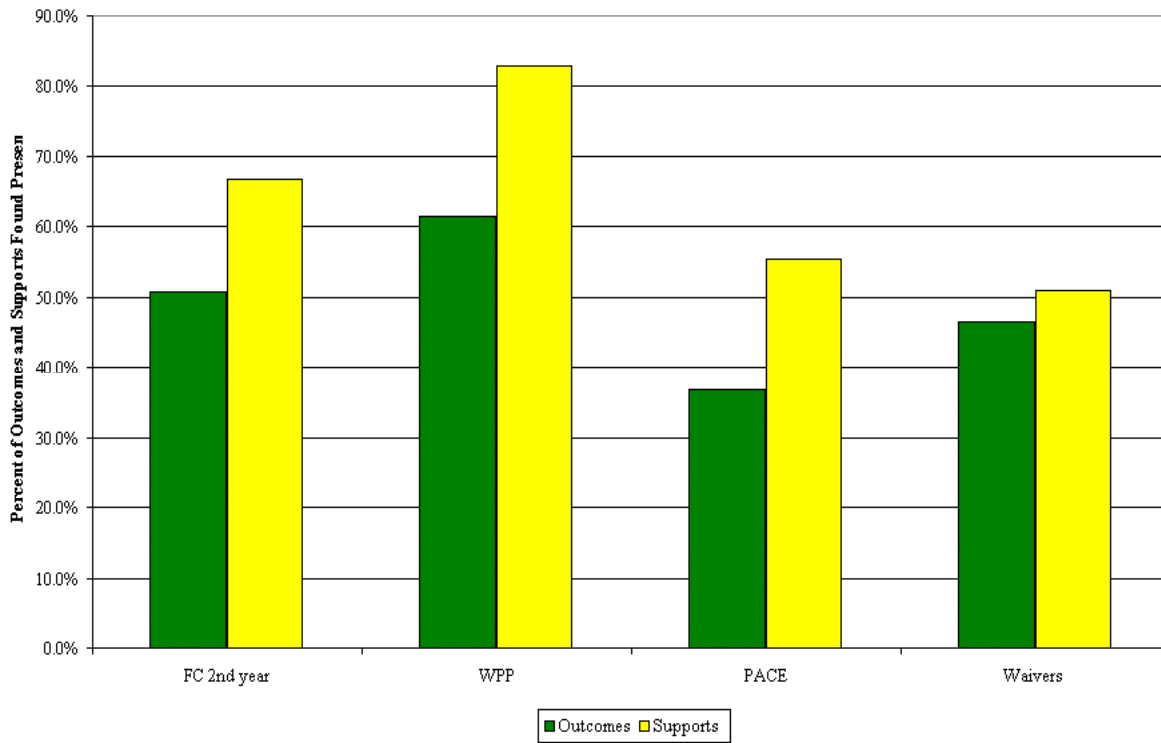
[6] It is important to note that the outcomes used by CQL were developed for people with developmental disabilities, not for the population served by WPP: the elderly and physically disabled.

Graph 5.

**Member Outcome Results for: "People Choose their Services"
Family Care (FC), Partnership (WPP), PACE, and Home & Community-Based Svcs.
Waivers**

Graph 6.
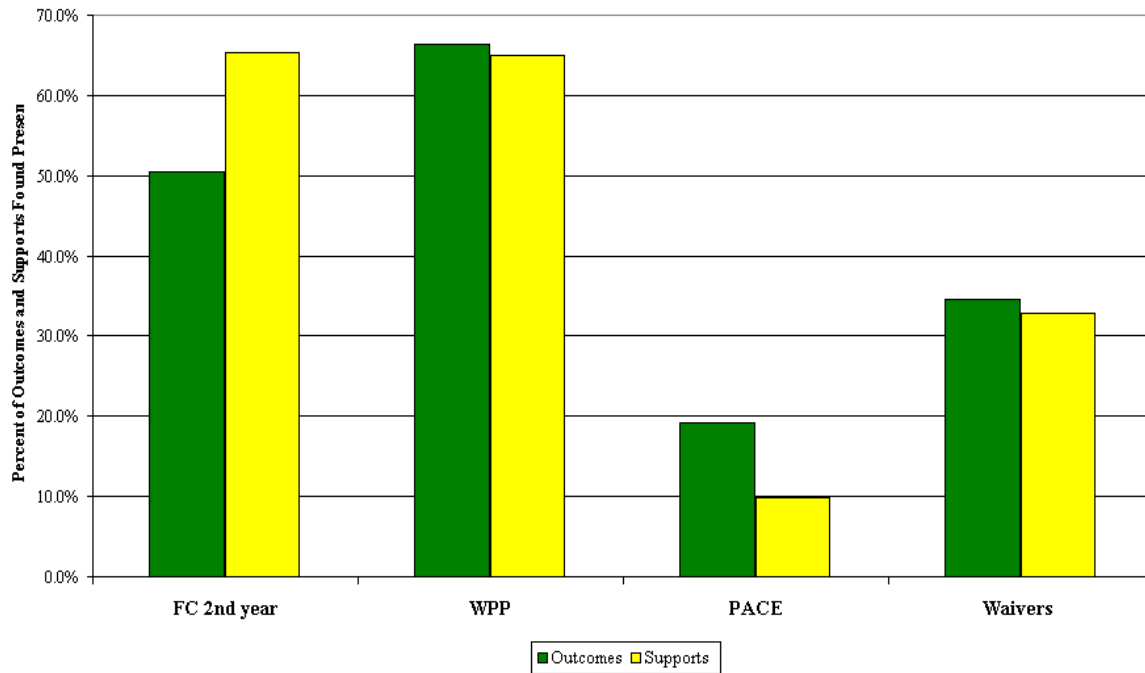
Levels of Satisfaction
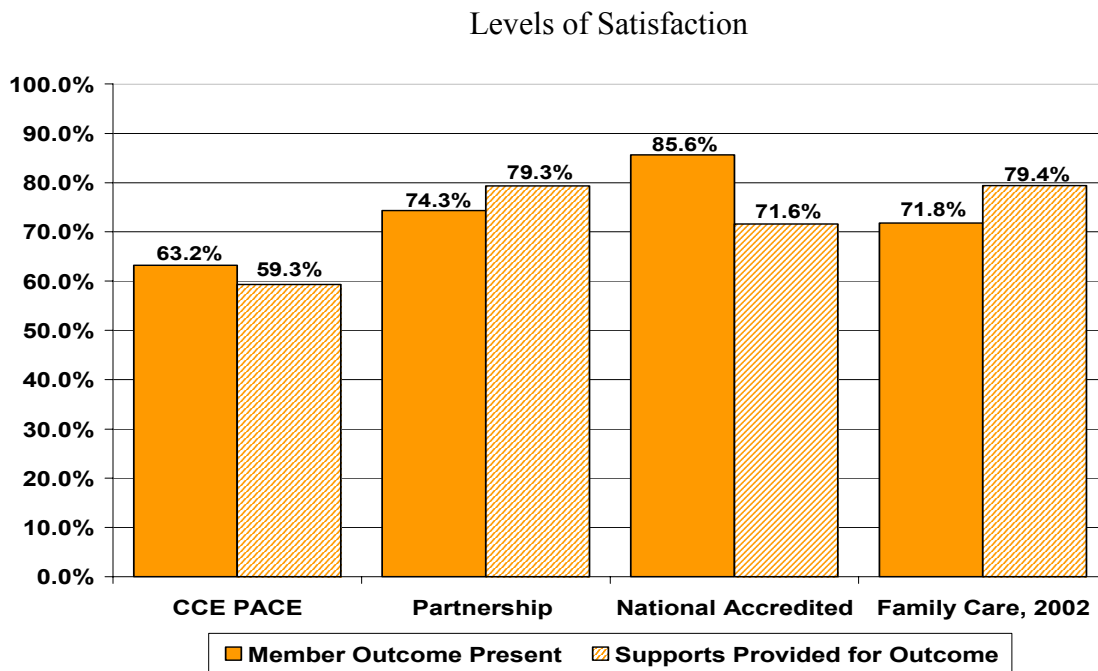
Provider Satisfaction

The Department has also conducted two provider satisfactions surveys. The surveys indicated a very high level of satisfaction with the amount of phone work and paperwork associated with the Partnership Program, as well as strong acceptance and approval of the care delivery model espoused by the Partnership Program by primary care physicians. Almost 85% of the physicians who returned the survey indicated that the involvement of the nurse practitioner promoted *"much more"* and *"more consistent follow through of medical recommendations"* as shown in Graph 7. This survey also identified the involvement of the physician in the Individualized Service Plan as an area for improvement.

Graph 7
Impact of the NP Role in Promoting Better
Follow Through of MD's Recommendations

"Does involvement of the nurse practitioner promote better follow through of MD's recommendations--filling & taking prescriptions, obtaining tests, coming to appointments?"
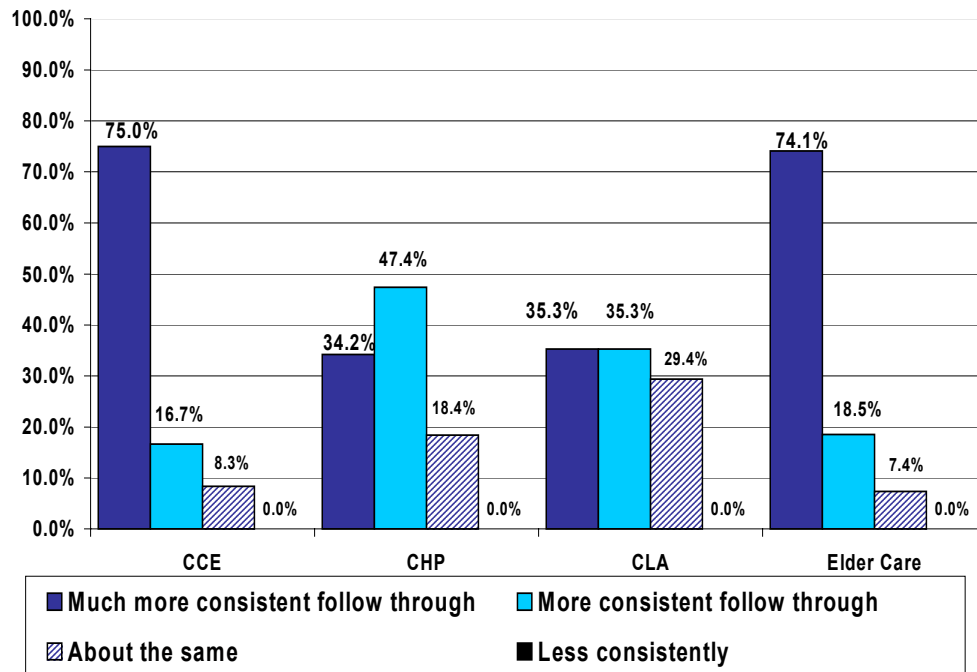
Quality Assurance/Improvement

The Partnership Program uses a multi-pronged, outcomes-based approach to quality assurance and improvement. Department staff compile and analyze utilization, diagnostic, enrollment and preventive care data. Department staff also monitor the organization's financial stability and trends, the quality of delegated/sub-contracted services data, the extent to which member-specified outcomes are supported and achieved, and the level of satisfaction experienced by providers and members. Complaints and grievances are reported and monitored on a regular basis.

Each Partnership organization conducts a minimum of two internal performance improvement projects (PIPs) annually. The selection of the PIP is based on utilization trends, incidence of adverse outcomes, and the diagnostic and age demographics of their membership.   Recent PIPs include (See Appendix L for sample QI projects):

- A Baseline study on Hemoglobin A1c Testing Using a Tickler Reminder System (2001)

- Use of First Generation Tricyclic Antidepressants in Participants (2001)

- Chronic Pain Assessment (2001)

- Caregiver Strain Study (2002)

- Medication Event Study (2002)

- Diabetes Performance Improvement Project (2002)

- Dementia-Related Behaviors (2002)

Additionally, the Department, Partnership organizations, and an external quality review organization (EQRO) collaboratively select and conduct an annual data-driven quality improvement project.   Recent EQRO projects include:

- **2001 EQRO Project**: Focused on falls/injuries and pneumonia by reviewing records and discussing events to identify best practices and opportunities for improvement.

- **2002 EQRO Project**: Reviewed the systems, structures, policies and procedures related to end-of-life (EOL) care and falls prevention.

- **2003 EQRO Project**: Studying hospitalizations for COPD because of its prevalence in Partnership members and the relatively high number of hospitalizations.

Conclusion

The Partnership Program has significantly reduced the need for nursing home care, reduced hospitalization utilization, and reduced hospitalization utilization for ambulatory care sensitive conditions. This, in combination of receiving capitation payments that are discounted from a fee-for-service equivalent population, has reduced the cost of providing health and long-term care to Partnership members.

Partnership members benefit from improved access to care, and integrated health and long-term care services as opposed to cost control as practiced in many managed health care programs.

The Wisconsin Partnership Program is meeting its goals of improving quality of health care and service delivery while containing costs and managing care to reduce fragmentation and inefficiency in the existing health care delivery system. Because of the Partnership Program, more people who are frail and medically complex are able to live in the community (where they choose to live) and participate more fully in decisions regarding their own health care.

Chapter 6
Target Population

Who is a Partnership Program Designed For?

The Partnership Program was designed for individuals who are dually eligible for Medicare and Medicaid and who meet the nursing home level of care. Therefore, the target population is low income, frail, chronically ill and/or disabled adults. The consumers in this target group are also relatively high users of both health care and long-term support services, and tend to "fall between the cracks." As a consequence, they often tend to experience serious, negative health outcomes including frequent hospitalizations and placement in long-term care institutions.

Characteristics of the Partnership Target Population

- Meet nursing home level of care and/or functional ability criteria.
- Chronic, disabling health conditions
- High levels of functional dependency
- Low income
- High service users

Any consumer who was low income and 'disabled' is considered eligible for enrollment in the Partnership Program. One of the initial Partnership sites planned to focus on the non-elderly disabled population, while one planned to take both elderly and non-elderly and two others planned to recruit only elderly. Individuals with primary mental health diagnoses and developmental disabilities were eliminated from the pool. While the Partnership Program staff were interested in both of these populations, they decided to begin with a focus on elders and individuals with physical disabilities and illnesses. As

membership grew in the Partnership Program, however, it became apparent that the target population initially envisioned was somewhat different than the group that ultimately enrolled.

Non-Elderly, Physically Disabled Partnership Population

Disability

The first surprise was that the under 65 group who enrolled in the program was disabled primarily as a consequence of chronic conditions such as diabetes, arthritis, multiple sclerosis and peripheral vascular disease. This was quite different than the young physically disabled group anticipated by the Partnership Planning Team. The Planning Team had expected to see individuals with disabilities related to accidents, injuries and birth trauma. This difference in   enrollees was likely related to the high visibility of this latter population in the disability rights movement and the association of these conditions with the term 'disability.' As it turns out, there were considerably more individuals with chronic medical conditions that, over time, resulted in high levels of disability. This is important since it has implications for the expertise of Partnership staff and the physician group working with and caring for Partnership members.

Age

The second surprise was the relatively older age of the 'young' disabled group. The Partnership design team had anticipated a group of enrollees in their late 20s to mid 40s. The group that enrolled was primarily mid 40s to almost 60. For example, at the Community Living Alliance Partnership site, the membership breaks down as follows[7]:

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[7] Per Sara Roberts, Oct. 2003

Age	Percent of Membership
20-44	36%
45-59	51%
60-64	7%
65-74	6%

This age distribution has important implications for service types and intensity.

Mental Health and Substance Abuse

Partnership members in the non-elderly disabled population had a relatively high incidence of long-term mental health and substance abuse problems, along with their physical disabilities. Although none of the members had either of these as a primary diagnosis, the problems were often severe and long standing. In the view of the Partnership staff, most of these individuals could easily have had a primary diagnosis related to their mental illness. The severity and impact of the mental health and substance abuse problems proved to be very challenging. Subsequent staff hiring and training has responded to this need.

Because diagnoses of mental health are much more prevalent in this population, Partnership Programs will need to address these issues by developing expertise in this area. Across the board, Partnership staff felt that managing consumer mental health, especially for younger members or those with undiagnosed issues, was one of the most complicated aspects of member services. Potential Partnership programs should prepare for this accordingly.

Elderly Disabled Partnership Population

Illness and Disability

The group of older adults who enrolled in the Partnership Program had both high levels of functional disability and highly complex medical conditions. This group tended to have multiple medical problems rather than one or two. A typical consumer profile would be someone with advanced diabetes, perhaps an amputation, unstable coronary artery disease, arthritis and gall bladder disease. Many elderly consumers also suffered from vision and hearing impairments, periodontal disease with multiple tooth loss, and chronically poor nutrition. It was not unusual for these members to have complex family problems, including other family members with mental health or substance abuse problems, caring for dependent adult children or grandchildren, living in relatively inaccessible or substandard housing and having very limited access to transportation.

Because of the multiple and complex health problems that many of these members experience, close and careful monitoring of medical conditions is often required. Many of these members live 'on the edge,' continually at risk of developing serious complications from their illnesses and experiencing frequent acute 'events.' Their treatments are often finely balanced, attempting to minimize side effects of treatment while also controlling symptoms of illness and preventing physical decline. What distinguishes this group is the precarious nature of their medical situations and how quickly they can go from 'stable' medically, to needing quick and intensive intervention. This is the medically fragile group.

This is quite different from a consumer group that has a high level of functional dependence with stable chronic illness. The urgency of response, the sophistication of medical management and the multiple back up systems necessary to serve this group must be structured into the Partnership design.

Implications of Partnership Enrollment Trends

The characteristics of Partnership members have important implications for planning and implementing a Partnership Program. For example, a high level of functional disability requires quite different services and staff expertise than does a high level of medical complexity. Effectively working with a population that has a high level of mental health and substance abuse problems requires expertise that most long-term care and health care providers do not have. Not having mental health expertise on a team that is trying to provide services to members with serious mental health problems is frustrating for staff and consumers alike, and also undermines care quality.

Failure to manage mental health and substance abuse problems effectively also has serious financial implications for the organization. Addressing mental health and substance abuse in a chronically ill population is a key component of effectively managing medical problems and keeping consumers out of costly environments. Many of the non-compliance issues that teams confront have mental health or substance abuse as the core issue. Staff who are inexperienced or lack the knowledge of how to deal with these issues spend considerable time venting frustrations and often engage in on-going battles with the consumers. Meanwhile the consumer's medical condition may be moving

toward crisis. This special expertise has been built into the program through ongoing

training and targeted hiring of experts.

Case Example

Louis a 45 year old, has been paraplegic for 10 years since his spinal cord injury from a gunshot wound. His team tried very hard to help him understand the importance of taking his meds on a regular schedule; however Louis would say "I don't like taking pills, I only take them when I need them." Consequently, he would have frequent crises of muscle spasms and bladder spasms and not being able to sleep, then saying the medications don't work. Louis drank heavily and frequently also which resulted in him being evicted from several apartments and staying in his wheelchair all night and developing skin breakdown. He finally agreed to go into treatment with the result being he was no longer evicted and had a stable place to live. The team feels he is still drinking some but he is doing much better. They realized that his drinking was at the root of his not taking his medications as prescribed. However they are still struggling with getting him take to his meds on a preventive basis and to change positions frequently. They feel that he hasn't really accepted his disability or taken on responsibility for getting on with his life. Recently however, he has taken on the responsibility for his 10 year old daughter and seems to be more motivated.

Case Example

Melody is an obese 31 year old with fibromyalgia who lives by herself in a very cluttered apartment. She has a diagnosis of PTSD, and an undocumented but suspected personality disorder. She sees a counselor 2-3 times a week and a psychiatrist monthly for med management. Melody has a long-standing relationship with her PCP and sees him weekly or every other week. The IDT is very frustrated with her as she is always asking for "things" and won't try other interventions that they suggest. For example, she wants more cab rides, a new walker and a hospital bed, while the team wants her to try physical therapy and other interventions. When the team explains that this is how they approach similar problems with other members, she says, "There is no one else like me." While she states she needs personal care services to wash her hair and for meal prep because she fatigues easily, she frequently goes out of her home to movies or to warm water exercises at the health club for pain management and weight loss. When confronted with these observations, she states, "nobody understands me." The team gets very frustrated because she won't enter into a dialogue with them and sometimes calls management. If she hears "no" from one team member she will then ask another and misconstrue what was said, in essence "splitting the team". The team has learned that they must always take time to reach agreement among themselves before responding to a request. They continue to experience frustration.

Case Example

Charles had been living with his daughter, who also had a substance abuse problem, for the last six months. His social security checks went for their rent and food. However, they were on the verge of eviction for non-payment when Charles was referred to the Partnership program. During the Intake interview he admitted that he had been a long-time user of heroin; he figured they would know anyway the first time he needed to have blood drawn, as he was the only one who could still locate a vein. He also admitted to having substantial credit card debt and not having money to buy his medications. He suffered from congestive heart failure, emphysema, diabetes and peripheral vascular disease and was a frequent visitor at the local ER.

He was surprised when, after meeting his team, the social worker told him that he was responsible for his own housing and suggested what to do about the risk of eviction. After two ER visits in the two weeks after enrollment, he was weakened and unable to walk or handle his personal cares. Blood tests at the ER showed evidence of recent heroin use. He was disheveled, frail and his chronic illnesses were unstable. The social worker told him that she had found a CBRF, run by an RN, who agreed to take him only if he didn't use and submitted to drug tests any time he left the facility. He reluctantly agreed, but cursed and blamed everyone for his current state.

The next nine months was a rocky journey for Charles and the team. With the help of psych consults, management intervention and facilitation, boundaries and limits were set and roles and expectations clarified. While Charles continues to reside in the CBRF, he now considers it home and realized that he wouldn't be able to stay "clean" outside of the structured environment. He is clean, well-dressed and enjoys writing his poetry for and telling his stories to his team. While he has had no ER admissions in the last nine months, he has recently learned he may need to go on dialysis in the near future. He feels that with the help of his team he will be able to handle it.

What is Different About Partnership Populations?

Typical Partnership members are not the consumers or patients that are courted by managed care organizations. They are, in fact, the individuals these organizations are trying *not* to enroll because of their complex medical conditions. This actually makes recruiting for Partnership somewhat easier. The consumers in Partnership Programs are often the individuals that frustrate other providers.   Sometimes that frustration is related to the difficulty of the physical, mental and environmental problems, issues and challenges that providers are trying to respond to or manage. Sometimes it is because these consumers are seen as uncooperative, noncompliant, and difficult. These are the consumers who will be enrolling in your program.   While they are time consuming and challenging, the long-term rewards of developing trust, decreasing hospitalizations and promoting independence and self-esteem can be satisfying.

Voice of Experience

Expect a wide variety and complexity in the issues your consumers will bring. Educate yourself on the issues typical to the population in your community to avoid too many surprises.

Part II.

Organizational and Program Development

Chapter 7
How a Partnership Program Changes an Organization

Introduction

The Partnership Program is indeed a program, a collection of activities that an organization performs in order to meet its goals. It is not, in itself, an organization. Each of the Wisconsin Partnership Program providers was an existing organization, with its own history and culture, and each remains an entity distinct from the program. However, adoption of the Partnership Program required changes on the part of these organizations. Some of these changes were expected or sought; others were a surprise. Some were welcomed; others felt like a loss. All should be taken into account by any organization considering the development of a Partnership Program.

Voice of Experience

Each of the Wisconsin Partnership Organizations hired organizational development consultants to help transition to its new size, function, and community role.

Every organization has a history, a culture, and a set of values and assumptions about its role in the community. It develops formal and informal systems that translate into "how we do things around here." Before developing the Partnership Program, each of the four Partnership providers was a community-based nonprofit organization that provided human services and/or advocacy to the elderly and/or disabled. One was an established PACE provider. Each had a culture and systems that worked for its current activities.

Adoption of the Partnership Program required change on the part of these organizations. Some of these changes were simply due to the sudden growth of the organizations. Others resulted from the very nature of the Partnership Program.

Impact of Organizational Growth

Significant organizational growth, from any source, changes an agency. Habits of communication and coordination, which worked fine before, often prove inadequate for the new demands. Out of necessity, systems become more formalized and processes become more standardized. These can be unwelcome changes to those who value small size and informality in the workplace and feel these are indicators of some key organizational value, such as accessibility. One Wisconsin Partnership Program manager described such a situation as an "internal struggle of 'we don't want to give up this grassroots identity and become hatchet men in blue suits.'"

Openly discussing organizational values and identifying ways to support these, regardless of the size or operation of the organization, have addressed these potential conflicts. Wisconsin Partnership Program managers stress the need to be clear about the organization's mission and to articulate how decisions relate to that mission. They also emphasize the importance of open communication within the organization and the need for leaders to model the values they promote. When managers show interest in hearing stories about members, it reinforces to staff that the managers care about the clients who are served and the staff who work hard to serve them.

Managers have used strategies such as open forums and regular administrative updates, including discussion of challenges and barriers the organization is facing. Providing staff with information, explaining why decisions are made, and discussing the intended impact on the organization help staff develop trust and understand and support even difficult decisions. Managers may also want to attend interdisciplinary meetings occasionally and help resolve difficult conflicts with families or members. This give managers and administrators the opportunity to interact with staff on issues core to the mission and values of the organization and stay connected with staff.

Organizational growth can also influence how an organization is perceived. As one manager said, "People fear big organizations; you know that all nonprofits ought to be real small and struggling, and if you get bigger, it automatically means you're bad because you're impersonal or you don't care about your customers." Because such perceptions can damage an organization's relationships with stakeholders, care must be taken to communicate openly and consistently with key constituencies. Regularly scheduled meetings and updates on plans, progress, and challenges will help stakeholders stay supportive, and articulating and demonstrating commitment to the mission and values as the organization grows may help dispel stakeholders' fears. One Partnership

organization found that regular meetings with the local home health agency helped the organizations to better understand each other, appreciate each other's challenges, and find new ways of working together. What was initially seen as competition became a mutual source of referrals for each organization's specialized services.

Impact of Specific Partnership Program Changes

Adoption of a Partnership Program also requires an organization to develop in specialized ways. It must develop both the service capacity to deliver a full range of primary, acute, and long-term care services and the interdisciplinary teams to provide these services in an integrated manner. It must also develop the capacity to manage several levels of risk (financial, individual member's health care, liability). See page 181 for a more detailed discussion of these risks.

Adoption of an interdisciplinary team-based program requires organizational members to question their assumptions about the health and social service professions. Much of this manual focuses on how interdisciplinary teams can be developed, but it is important to note that the organizational infrastructure must support these efforts. A good example of this is reporting relationships.

Some of the Partnership sites shifted from a reporting relationship that stayed within a single discipline to one that integrated disciplines. For example, at one site each team member initially reported to a supervisor who oversaw all workers in that discipline. So the Partnership team nurse reported to the nurse supervisor while the team social worker reported to the social work supervisor. This maximized the possibility for conflict and divisiveness within the team. The structure was changed so that all team members reported to a single supervisor whose responsibility was to promote collaboration and good working relationships among team members.

The decision to deliver health care services can alter how a social services organization sees itself and its work—and how others see it. For some organizations, "health care" is so negatively associated with a medical model of care that its incorporation would seem to conflict with the organization's basic values. Demonstrating to consumers and consumer advocates that you are sincere and will be effective at providing high quality, consumer responsive care may be a challenge. In particular, the sites that were built on

Independent Living Centers were seen as suspect.   Suspicions seemed to be primarily about:

- Loss of an advocate status that comes with collaboration

- Fear that medical practitioners would overrule everyone else

- Fear that consumer choice will be lost

- Necessity of being concerned with cost of services

Although Partnership Programs have demonstrated to consumer advocates and consumer groups that close collaboration with health care providers can actually increase the likelihood of consumer-centered care, a perceived conflict in philosophies may still alter the organization. In fact, one Partnership organization resolved the conflict by creating a separate organization that developed the Partnership Program.

> "We ended up starting … a separate service organization because there were a lot of questions in the minds of a lot of advocates in the disability movement about whether an independent living center could do the kind of service provision we could do and still do uncompromised advocacy."

Even social service organizations that do not restructure may find themselves facing an identity crisis when they realize they must hire one of "them," a health care professional, early in the planning process to gain "insider knowledge." This means finding someone who may speak a different professional language, may appear to have slightly different values, and feels quite unfamiliar. This may well be uncomfortable, unfamiliar, and unappealing to the organization. In some of the more ideologically committed social service organizations, these new comrades have long been considered the enemy. These

are the people who are seen as the force behind the "medicalization" of consumers' lives, the people who take away self-determination and use all resources for things that most consumers, given the choice, would forego. But these are the people who will be needed in the organization if it is to effectively integrate fiscally and clinically sound decisions with consumer preferences.

The Wisconsin Partnership Program organizations also had to learn to manage unfamiliar forms of risk. They were becoming both service and insurance providers for populations that, compared to the general population, were heavy consumers of health care services. By insurance industry standards, all of their members would be "high risk." Partnership organizations had to develop the capacity to deliver the needed services, in a consumer-centered manner, and to collect and use information that would allow them to manage their financial risk.

Wisconsin Partnership Program organizations accept full responsibility for meeting members' health and social service needs and realize that their decisions could put members at physical risk. The medical aspects of this responsibility require an organization to function in ways that the social service aspects alone would not. Health care services are highly professionalized and have very specific quality control procedures. Such standardization, and the need to have complete procedures in place *before* a need arises, may be unfamiliar to social service managers who often use a reactionary decision-making style in managing their under funded organizations, an approach that could be called "make-do-as-we-have-to" or "just-in-time" capacity

building. This approach does not work in health care. As one Wisconsin Partnership Program manager put it:

> "People on the social services end of things don't necessarily have a good understanding of what it takes to be a provider of medical services and nursing services. In particular, people don't realize that there are certain ways to do things according to standards of practice and that you really can't bend the rules."

Another admitted, "I didn't fully understand what all was involved (in medical care) and number two, I thought we could just sort of add on that as we needed to, that most of it was going to be social work."

Voice of Experience

Wisconsin Partnership Program managers advise social service organizations that take on a Partnership Program to assume that "you don't know what you don't know" about medical care and seek guidance from the health professions. Once standard professional procedures are in place, the organization can consider ways to assure that the care provided is consumer-centered.

Wisconsin Partnership Program organizations operate under a fully capitated system. This places the organization at financial risk and puts it in the potentially conflicting role of acting as both provider and payer of services with its members. As one founding manager of a Wisconsin Partnership Program said, "When you are the payer and the provider, it makes for a very complex working environment for staff. On one hand we must arrange for and monitor services, on the other hand we are paying and are not a

disinterested party. We wear different hats at different times and must be aware of the complexities."

Managing these complexities requires organizations to have systems that will allow them to make good care decisions while, at the same time, not putting themselves at unnecessary financial risk. The Resource Allocation Decision (RAD) Methodology (See Appendix P) has been very helpful to the Wisconsin Partnership Program organizations in evaluating the need for requested services. One Wisconsin Partnership Program has also developed an assessment tool for evaluating the "social necessity" of a request for service (Appendix Q). All Wisconsin Partnership Programs continue to work on developing information collection and analysis systems to aid in care decisions.

The one Partnership Program that had long-standing experience operating a PACE program found it had unique challenges when it adopted the Partnership Program. Unlike the other three Wisconsin Partnership providers, it had extensive experience providing health care services under a capitated model. Its challenge was to develop community-based services. In the PACE program, members come to a central location for services and the physicians are employees of the organization. Under theses circumstances, monitoring members' conditions and overseeing the costs for physician services are relatively easy to manage. Since Partnership Program members receive care in their homes and keep their own doctors, new systems that relied on the role of the nurse practitioner had to be developed. Time and resources need to be devoted to ensure that the nurse practitioner role is utilized to its fullest potential. This means educating

community physicians about the nurse practitioner role, program values, and provider expectations.

Adoption of a Partnership Program is also likely to require changes for the Board of Directors. As the organization grows and takes on entrepreneurial risk, the board must reconsider its role and adopt an appropriate style of oversight for the emerging organization. Wisconsin Partnership Program managers and board members have stressed the importance of the board trusting the staff to do its job. In a rapidly changing environment, board involvement in operational decisions can stall and, ultimately, block progress. The board must develop mechanisms for providing responsible oversight without micromanaging.

Several Wisconsin Partnership Program boards have done this through a deliberate process of articulating the organizational values that should guide decision-making, clearly defining the Executive Directors' responsibilities and evaluation criteria and establishing mechanisms for monitoring these. John Carver's model of board governance[8] was helpful to some Wisconsin Partnership Program boards in this board development process. Explicit board development efforts were needed in both the new boards of the new organizations that were formed to provide the Partnership Program and in the existing boards of the organizations that expanded to incorporate the program.

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[8] Carver, John. Boards That Make a Difference: A New Design for Leadership in Nonprofit and Public Organizations (2nd Ed.) (1997). CA: Jossey-Bass.

Voice of Experience

The role of the Board of Directors will need to be reexamined in those organizations that adopt a Partnership Program.   Wisconsin Partnership Program organizations recommend getting professional board development assistance with this process.

As Boards are developed it's important to consider whether and in what capacity consumers should be involved. One approach to develop a consumer-centered Board is to have at least 50% of the members consist of consumers. While this ideology is well intentioned, there is no assurance that consumer representation on a Board of Directors ensures the quality of consumer-centered care. More importantly, consumers may feel uncomfortable being involved in discussions about technical and financial aspects of the program.

Given these considerations, WPP decided to have a small number of consumers represented on their Boards of Directors. Consumer representatives were especially helpful in focusing on the development and improvement of specific services.

Chapter 8
Steps to Program Adoption:
Pre-feasibility

Introduction

Before developing a Partnership Program, an organization must conduct a comprehensive feasibility study, which can be expensive and time consuming. Before undertaking a formal study, potential Partnership organizations should plan carefully and conduct preliminary assessments of themselves, their communities, and of the state's interest in supporting such a program.

Organizing to Plan

Development of a Partnership Program is a complicated process that requires having the right people doing the right things at the right time. Staff from each Partnership Program claim they would have benefited from more extensive planning, a more deliberate strategy for deciding whom to include on the planning team, an earlier start to their planning, and more focused and informed planning.

Voice of Experience

Administrators from every Partnership site emphasize the importance of planning well in advance of program start-up. Planning should start at least 12-24 months before the first member is enrolled

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What to Plan

For organizations that are planning to build an integrated care model on an already existing community-based, social-service delivery program, it is imperative that staff be

informed about what this entails so that they can build appropriately. Wisdom from each

of the Partnership sites reinforces the significance, magnitude, and difficulty of making

the shift from a social service to an integrated social/health services program. Becoming

responsible for the provision and oversight of health services for a population with

complex medical needs requires the development of new expertise, new systems, and

new community relationships. It also renders the organization subject to a

comprehensive range of health service regulations.

Partnership staff describe the main planning tasks as follows:

- Building a provider network in the community,

- Building credibility among potential consumers, providers and the
  general community,

- Securing contracts with adequate and appropriate service providers

- Developing internal care delivery and administrative policies and
  procedures,

- Developing an adequate and appropriate infrastructure that includes
  financial, information systems, and clinical expertise, and

- Developing the actual care management team(s).

Who to Include: Partnership Planning Committee

Organizations considering Partnership will need to create a Planning Committee

consisting of staff who can focus their time and attention on the planning activities

necessary for development of a Partnership Program (See page 129 for a description of

Partnership's internal and external committees, their role, and their potential

membership).

The Planning Committee includes members who represent key areas of the organization such as:

- Executive director/CEO,

- Finance,

- Operations,

- Information systems,

- Service providers including clinical or health-related,

- Quality improvement, and

- Marketing/public relations.

It is useful for the Planning Committee to assign a point person or leader who has overall knowledge of the organization, good understanding of the Partnership model, and authority within the organization to make decisions. The committee will need to budget and staff for support services necessary to assist the committee in its planning functions. Establishing regular, structured meetings and developing work plans and timelines to guide the group in meeting its goals is a critical function of the Planning Committee. Regular updates and reports should be shared with the organization's board of directors to keep it informed and invested in program development. The Planning Committee will also need defined authority from the organization's executive(s) and board of directors to make decisions on its own rather than experiencing lengthy delays waiting for the next board of director's meeting. Having a structure in place that allows for a rapid turnaround time for direction and decisions will facilitate program development. For example, the board of directors may delegate its executive committee the oversight and

decision-making responsibilities for the planning process. This committee could meet more frequently or on short notice to consider key planning questions.

Role of Medical Director

Partnership Programs agreed that bringing a Medical Director on board early in the planning process was important. As a member of the Planning Committee, the Medical Director brings key, clinical expertise to the table while gaining better understanding of all aspects of the integrated care program.

Voice of Experience

Partnership Program staff consistently emphasized the importance of having the medical director on board from the beginning. Don't wait to hire this person even if s/he is expensive. Not having the medical director jeopardizes the development of important relationships. Early inclusion also increases the personal investment of this medical director and creates an opportunity for the medical director to help shape the design of the program.

Don't underestimate the time needed from the Medical Director before your "doors open." There are a variety of important strategic things that Medical Directors can do in this early phase. Some of these include:

- Networking, marketing, and educating other physicians about the program and benefits to both consumers and providers;

- Developing protocols for managing medical problems that community physicians struggle with;

- Developing protocols for consulting with Partnership team and medical director;

- Providing education and consultation to community physicians and other groups on the medical needs of the population;

- Developing competencies for providers both inside and outside the Partnership organization who are working with the consumers;

- Meeting with State representatives to facilitate the development of oversight, accountability and benefit issues of relevance to this population;

- Participating in the development and/or integration of information systems that will be used to monitor the population for clinical, policy and organization uses; and

- Evaluating potential new members to determine eligibility and service needs.

It is important to have a medical director who is respected in the medical community, has experience or expertise with the target population, and if possible, has a caseload of consumers who are eligible for the Partnership Program. This will increase the likelihood of enrolling a group of consumers and will increase the acceptance of the program among consumers and advocates.

If a medical director is not included on the planning team during the pre-feasibility phase, then he/she will certainly need to be included when the organization begins exploring relationships with potential providers.

One of the Partnership sites began with a medical director who seemed a perfect fit – ideologically, a real consumer advocate. Unfortunately, this physician had not kept up with current practice and was not highly respected by physicians in the community. When one of the Partnership members was seen in a local emergency room, the attending physician told the Partnership nurse:

> "What are you doing with her? She can't take care of these really
>
> complicated patients – No one will take your program seriously if you
>
> don't find a different physician."

Needless to say, it is much easier to have the right physician on board from the beginning. The above situation eroded the program's credibility and created a crisis for the program. The physician has to be terminated and a new one found.

Voice of Experience

Some of the Wisconsin Partnership Programs sent non-medical staff to meet with potential Partnership physicians as the program was being developed. Very few of these contacts led to physicians joining the Partnership panel. The questions potential physician providers are interested in are primarily about clinical issues and can only be answered by another physician. In addition, assurances to physicians about the clinical quality of the program are only credible from the Partnership medical director. This will require specific knowledge about usual practice, hospital, and clinic operators in the area, and on call systems. It may be useful for a nurse practitioner to accompany the physician on some of these visits so that the potential physician can interact with them as a team. This is important since the nurse practitioners will be very involved in the medical management of partnership members.

Internal Readiness

Managers of Wisconsin Partnership Program organizations have identified several organizational characteristics that they would consider to be prerequisites for Partnership Program adoption. The first of these is passion and faith that the Partnership Program is "absolutely the right thing to do." Adoption of a Partnership Program brought so many challenges to these organizations that staff often felt they were sustained only by the commitment to the Partnership Program philosophy and the belief that the program would benefit their consumers—and ultimately the organization. Although we believe that the next generation of program developers will not face the same learning curve as the pilot programs, Partnership managers still consider this commitment and passion to be essential

to program success and believe a Partnership Program should not be attempted if it is attractive only as a potential income stream.

Another organizational characteristic that Partnership managers consider to be a prerequisite to Partnership adoption is a willingness to accept risk. The integrated care approach requires the organization to accept responsibility for the well being of its consumers, not just for the quality of individual services delivered. It must be willing to accept that risk. When funded under a capitated system, as it is in Wisconsin, adoption of a Partnership Program also means that an organization is responsible for doing this with limited resources. There is the potential for cost savings, but the organization must also be willing to accept financial risk. Well-managed programs, careful staff development, good contracts and high skilled staff who work well together will minimize the risk.

Because adoption of a Partnership Program will bring about organizational growth and change, the organization must also be willing to accept changes in its size, structure, and image. These changes, along with the Partnership Program's consumer-centered interdisciplinary philosophy, at times, put organizational members in unstructured and/or ambiguous work situations. Many staff will be forging new roles, new practices, and new strategies for themselves in the workplace. The culture of the organization must attract and support a staff that is willing and able to work in this setting. It is also important that the organization not be conflict-averse.

For example, since allocation of resources to consumers must be based on need, the organization must be able to accept and communicate that it cannot meet all consumers' want. It is important for staff to be able to differentiate between want and need, while

keeping quality of life issues and values under consideration. While resource allocation decisions need to be flexible and individualized, they still need to adhere to a standard of "like decisions for like cases." (See RAD Methodology in Appendix P).

The demands of a growing organization and the realities of running a Partnership Program mean that, at times, hard and/or controversial decision will need to be made. Some decisions may be unpopular with existing staff and lead to staff turnover.

A potential Partnership Program organization must be willing and able to work with government bureaucracy. The infancy of this program and the nature of its funding require a close working relationship with state and federal agencies that probably do not have administrative systems developed to support or monitor it. A government agency may strongly support a Partnership Program on the philosophical level yet seem to create bureaucratic barriers to its success. Partnership programs are new. Everyone is learning how to work with them. Potential organizations need to develop relationships with the state that promote trust, collaboration, and shared problem solving when these issues inevitably arise.

If it is to establish itself as a credible in the community, a potential Partnership Program organization must also be willing to do whatever it can to build strong relationships with health care and other providers. This could require a change in the organization's image and/or adding specific people to the board or staff such as health care professionals, financial advisors, insurance agents, and Medicare and managed care experts. The organization must be open to these changes.

Finally, the organization must have risk averse, visionary leaders who demonstrate a willingness to change and a commitment to guide the organization through a sustained period of growth and change. This requires certain "nimbleness." Wisconsin Partnership Program managers believe that previous experiences with a program such as PACE would be helpful to a leader, but not absolutely necessary.

State Interest

The Wisconsin Partnership Programs are funded through a capitated system in which Medicaid and Medicare dollars are combined on the state level and paid to the organizations on a per member/per month rate. This arrangement allows the Partnership Programs the financial flexibility to design the best care possible for their members. It also requires that the state actively support the development of these programs. Without high-level state interest, a program funded as it is in Wisconsin will not be possible.

At a minimum, the state must be willing to apply for federal Medicaid and Medicare waivers, to work with the Centers for Medicare & Medicaid Services, and to commit to funding modifications in its Medicaid budget. Such state-level efforts usually require the support of state leaders/legislators.

State administrators must also be willing and able to support the development of an innovative program and be flexible in its expectations of Partnership pilots and demonstrations during the start-up period. This may mean developing new performance measures and regulations, which takes time. This also means staff time must be

committed to developing relationships with the state and finding ways to nurture and protect a program within an administrative system that is not designed to support it.

The state must also realize that Partnership is a long-term commitment. Although it is expected providers will become financially self-sustainable through this funding system, it may take years. In Wisconsin, providers needed assistance from the state in securing start-up funding and developing a "risk corridor" (see page 158 for details) that allowed the providers to assume financial risk for members' care incrementally.

Wisconsin Partnership Program managers recommend that Partnership not be a state's first experiment with this type of funding for health care. The Partnership Program was not Wisconsin state government's first experience with a managed care program. It had experience setting rates for such programs and moving individuals from a fee-for-service payment system to a capitated one. The state must also recognize that its unexpected demands for data or time increase the cost of organizations' provision of service.

Decision Point

The "Pre-feasibility Internal Assessment Checklist" and "Pre-feasibility State Assessment Checklist" in this manual (see pages 113 & 115) can help an organization decide if it will invest in the next step of assessing the market for a Partnership Program and begin building relationships to support it. A visit to an existing Partnership Program may also be helpful at this point.

Pre-feasibility Internal Assessment Checklist				
	Not Sure	Few Or None	Some	Most
1. Members of our organization understand and are committed to the Partnership Program philosophy of consumer-centered interdisciplinary care.				
Key Staff	☐	☐	☐	☐
Board of Directors	☐	☐	☐	☐
2. Members of our organization have expressed a belief that a Partnership Program would benefit the consumers of our services.				
Key Staff	☐	☐	☐	☐
Board of Directors	☐	☐	☐	☐
3. Members of our organization have expressed a willingness to have the organization accept additional responsibility for the well-being of consumers of our services				
Key Staff	☐	☐	☐	☐
Board of Directors	☐	☐	☐	☐
4. Members of our organization understand insurance-industry definitions of "risk" and how they apply to the populations(s) we may serve in a Partnership Program.				
Key Staff	☐	☐	☐	☐
Board of Directors	☐	☐	☐	☐
5. Members of our organization have expressed a belief that development of a Partnership Program will increase the financial growth of the organization.				
Key Staff	☐	☐	☐	☐
Board of Directors	☐	☐	☐	☐
6. Members of our organization have expressed a willingness to have the organization accept additional financial risk.				
Key Staff	☐	☐	☐	☐
Board of Directors	☐	☐	☐	☐
7. Members of our organization have expressed a willingness to change the size, structure, and image of the organization.				
Key Staff	☐	☐	☐	☐
Board of Directors	☐	☐	☐	☐

Pre-feasibility Internal Assessment Checklist

		Not Sure	Few Or None	Some	Most
8.	Members of our organization have demonstrated a willingness and ability to work in unstructured and/or ambiguous situations.				
	Key Staff	☐	☐	☐	☐
	Board of Directors	☐	☐	☐	☐
9.	Members of our organization have demonstrated a willingness and ability to make difficult and/or controversial decisions. .				
	Key Staff	☐	☐	☐	☐
	Board of Directors	☐	☐	☐	☐
10.	Members of our organization have the willingness and skills to lead the organization through a sustained period of growth and change.				
	Key Staff	☐	☐	☐	☐
	Board of Directors	☐	☐	☐	☐
11.	Members of our organization have expressed a willing-ness to work closely with state and federal governments.				
	Key Staff	☐	☐	☐	☐
	Board of Directors	☐	☐	☐	☐
12.	Members of our organization have expressed a willingness and ability (perhaps with state support) to establish credible relationships with health care and other providers.				
	Key Staff	☐	☐	☐	☐
	Board of Directors	☐	☐	☐	☐

Pre-feasibility State Assessment Checklist

		Not Sure	No	Yes
1.	The state agency is willing to apply for Medicare/Medicaid waivers for a Partnership Program.	☐	☐	☐
2.	The state agency is willing to work with the federal Centers for Medicare and Medicare Programs on behalf of a Partnership Program	☐	☐	☐
3.	The state is willing to commit to modifying its Medicaid budget to accommodate the Partnership Program.	☐	☐	☐
4.	A core group of state leaders/legislators supports the development of a Partnership Program.	☐	☐	☐
5.	The state can articulate where the Partnership Program would fit with its long-range goals for service delivery and financing.	☐	☐	☐
6.	The state agency is willing to commit planning time and money to the development of a Partnership Program	☐	☐	☐
7.	The state agency is willing to directly provide or find venture capital to support the start-up costs associated with developing a Partnership Program.	☐	☐	☐
8.	The state agency is willing to develop a "risk corridor" with Partnership Program providers that will allow the providers to assume financial risk for members' care incrementally.	☐	☐	☐
9.	The state agency has experience supporting the development of new service initiatives.	☐	☐	☐
10.	The state agency has experience administering managed care programs.	☐	☐	☐
11.	The state agency has experience setting rates for managed care programs.	☐	☐	☐
12.	The state agency has experience moving individuals from a fee-for-service payment system to a capitated one.	☐	☐	☐

Understanding the Results

These assessment tools cover the key areas of concern that have been identified by Wisconsin Partnership Program leaders and the following interpretations of the results are based on their recommendations.

- Any question on either of the assessments that is answered "Not Sure" indicates a need for further research in that area.

- At least seven of the twelve questions on the Internal Assessment should be answered "Most," and the majority of the remaining ones should be answered "Some," if the organization is to proceed.

- If there is strong interest in the Partnership Program in some parts of the organization but the majority of the responses on the Internal Assessment are "Some," or "Few," there are options to consider. If overall interest or understanding is weak, those with the interest may attempt to further educate other members of organization in hopes of building commitment. Those with strong interest may also consider spinning off a new organization to provide Partnership.

- However, if the responses to Questions 8-12 of the Internal Assessment are "Few or None," your organization probably should not proceed at this time since these questions refer to organizational characteristics that are key to the success of a program.

- If the responses to Questions 1-3 on the State Assessment are "No," then it is also unrealistic to proceed, since these state actions are necessary for Partnership funding. "No" responses to Questions 4-12 on the State Assessment indicate that the development of a Partnership Program will be very difficult.

Chapter 9
Steps to Program Adoption: Preliminary External Feasibility and Relationship-Building

Introduction

If an organization decides that it has the internal prerequisites to develop a Partnership Program, and that the State has shown sustainable interest as identified via the Pre-feasibility Checklist, then it is ready to explore external factors that would influence the program's feasibility. This chapter describes how to determine community interest in the program while initiating relationships that will be necessary for program development. Although these steps are presented in a somewhat linear manner, in reality, this process is iterative. For example, you may make an initial decision about the population(s) you are interested in serving and later discover there is a stronger felt community need or desire to serve a different population.

The Partnership program has been successfully adapted to different populations and settings. However, each organization considering the development of a Partnership Program, must decide on both the target population and the geographic area it intends to serve. In Wisconsin, Partnership Programs have served the frail elderly and people with physical disabilities. Some organizations have served one of these populations exclusively; others have served both. One program is currently developing services for individuals with both serious mental illness and physical disabilities. Some Wisconsin Partnership Programs serve urban areas; others are primarily rural. The choice of population served is likely to be based on the following:

- Organizational mission and past experience with the population(s);

- Perceived needs in the community; and

- Assumptions about numbers and location of members of the population(s):
  - The organization will need a "critical mass" of members if the Partnership Program is to be viable. See Appendix R for a sample of a marketing map.

Needs Assessment

Once an organization has made a preliminary decision about which population it would like to serve, it must determine the number of individuals in the service area that are potentially eligible for membership in the Partnership Program. In Wisconsin, this was estimated by using several data sources, including:

- Annual surveys of nursing homes;

- The State's Human Services Reporting System (HSRS) of health care waiver participants;

- U.S. Census, including tabulations on Mobility and Self-Care Limitations;

- Home and Community-Based Waiver Programs;

- Local waiting lists for persons seeking long-term support services; and

- Demographic census software that is able to identify low-income persons by age and zip code (i.e. Claritis).

A potential Partnership organization must also ascertain if the State is able and willing to provide specific information on the population, service utilization, and current costs. This information will be needed for a full feasibility study. Wisconsin had a system in place to gather most of these data and was willing to share it with the Partnership Programs. This may not be true in all states.

State Relationship Development

In the Pre-feasibility phase, the organization ascertains the State's interest in supporting the development of a Partnership Program. At this phase it is important to determine what the State would require of a Partnership provider and what informational resources the state could bring to its development.

To do this, first identify all the state agencies and departments with which the Partnership Program would have formal relationships. Since Partnership organizations are both providers and insurers, their government relationships are more complex than many provider organizations are used to. As a result, potential Partnership Programs should identify entities responsible for regulation, quality review, and reimbursement. There are also likely to be entities that could simply veto a Partnership Program's development. In Wisconsin, for example, the Department of Health and Family Services oversees the program, but the Office of the Commissioner of Insurance (OCI) had to approve an exemption to the HMO regulations in the state.

Next, establish a relationship with highly placed individuals within these entities and spend time educating them about Partnership programs. When doing this, it might be helpful to work with consultants who are familiar with these organizations. Then determine what these entities would require of the program. Possibilities include professional and financial standards (such as risk reserves), data, reports, and collaborative relationships with other organizations. It is especially important to find out if there are any legal or administrative limits to the size or uses of a financial surplus Partnership Program might generate.

You will also want to explore the reasons these state entities are interested in a Partnership Program and the criteria they will use to judge the success of the program. The more specific they can be about these criteria, the better. It might help to use a few case examples and walk through them together, discussing what would be a successful outcome and how the case would be evaluated. For example, one department or agency's primary concern may be reducing medical expenses for this population, while another may be primarily concerned with shrinking the wait list for services. These definitions of "success" should be made explicit. They will certainly surface later and misunderstandings or conflicting definitions can cause unnecessary problems. Find out how you will be held accountable. Sometimes the requirements of one department may be at odds with those in another department. It might be useful to gather people together from each of these entities to work out a plan that is acceptable to everyone and has approval of whoever has the authority to do so. It is vital to negotiate these requirements carefully. Be sure the agreements are written and signed by those in authority to do so.

Delivery of health care services is highly regulated. If your organization has not provided health care services in the past, there are many new requirements you will have to meet. These include a range of policies and procedures such as infection control, resuscitation policies, and training programs. Some of these requirements have implications for the physical environment such as secure rooms for medications or sinks for hand washing. It is important to learn what these requirements are before purchasing, renting, or renovating space.

There are also important licensing and certification requirements for staff such as a current license to practice. These need to be reliably updated annually, which includes procedures such as criminal background checks. Systems will need to be put in place to monitor these, as well as addressing liability insurance for all staff and advanced practice requirements for nurse practitioners.

Quality oversight will also change significantly for any organization adding health care services. The Wisconsin Partnership programs experienced some challenges because of the inconsistency between quality standards applied by State regulators and the mission of the program. In some instances, the State's requirements for quality oversight may not have complemented the Partnership Program's goals for consumer-centered quality or quality oversight with provider networks.

For example, during an external quality review, a nurse reviewer who was experienced in hospital and home health recommended that a member and his wife be placed in a nursing home due to medication noncompliance. The reviewer also wanted to cite the Partnership agency even though the Partnership team was aware of the situation and had assessed it as safe, though not ideal. The consumer's wife, who was cognitively sound, made daily decisions about which of her husband's medications she would administer. Though there had been no serious negative consequences, the team was actively working on problem-solving the issue with her. The nurse reviewer's perspective that medication compliance was more important than continuing to live in one's own home clearly influenced the external quality review. Issues such as these should be anticipated and planned for.

As this example illustrates, state requirements may or may not address all aspects of quality as promoted by Partnership. As a result Partnership Programs should ensure, at a minimum, that state requirements are met, but they should also continue to develop their own comprehensive approach to quality. Finally, the organization will need to decide for itself what would be unacceptable in a State contract or State oversight.

Voice of Experience

Wisconsin Partnership leaders recommend that, after gathering information from the various state entities that would influence a Partnership Program, the organization do some serious soul-searching to decide if operating a Partnership Program under these circumstances would be acceptable, given the organization's mission and values. If there are potential problems, don't give up before you attempt a collaborative agreement among state agencies.

The Process of Building Community Relationships

Each of the Partnership Program sites emphasized the importance of building relationships in the community right from the beginning of the planning phase. There seems to be a tendency to delay these contacts until later in the process. The ability to provide comprehensive, integrated care depends on good working relationships with a wide range of providers and respect from the general community. The challenge for a budding Partnership Program is to cultivate this extensive network very early in order to be seen as credible and to assure that Partnership consumers will have access to all the services they need. Relationships will need to be built with both community stakeholders and members of the current service network such as hospitals, physicians, and consumer rights groups. There will probably be some overlap between these groups, but their

interests and concerns can differ, so they should be considered separately. Details about assessing and building relationships with the local service network are discussed on page 138.

When considering the process of building community relationships, it may be helpful to think about the various "players" involved, both inside and outside the organization and how to deploy them. Within the organization are those who will be presenting the "face" of the Partnership Program to the community. These include members of your Planning Committee (see page 106) and, at this point, will also include a Medical Director.

Voice of Experience

These early conversations will not only provide you with important and useful information but will also form an impression of your organization in the community. Therefore, it is important to think through who will make contact with each organization, what each contact could achieve, how you wish to be perceived, what information you need, and what messages you wish to leave.

Your objective in talking to community members is threefold. You want your audience to acknowledge Partnership and its unique approach to long-term care, to support and endorse the program, and, ultimately, to agree to contract with the program. To create this community buy-in, your message should highlight Partnership's strengths including the proven benefits to consumers who consistently report high satisfaction with the program and the proven benefits to the provider community as a result of the collaborative, team approach to care management.

As discussed earlier (see page 106), the Medical Director will be instrumental in conveying these concepts to the community and creating credibility for the Program. How well this message is delivered and the impressions made through these contacts will have a lasting impact on the quality of the program's relationships with the community and will ultimately determine the likelihood of the Partnership Program being taken seriously.

Role of Community in Partnership Development

The Partnership Program will be serving persons living in the community and will rely on community providers to deliver services for its members. Therefore, it will be important to identify key community stakeholders—consumers, providers, government agencies, and local officials—to participate in and oversee the planning and development of the Partnership Program.

Wisconsin's Partnership Program staff believed it would have been beneficial to include community stakeholders much earlier than they did in the planning and development of their programs. When the original Partnership Programs received funding from the Robert Wood Johnson Foundation and authorization as a demonstration project, much of the focus was on the relationship between the State and the community-based organizations that would be building the program. Because of the timelines and the fact that there was limited, if any, experience to guide the process, the organizations were under a great deal of pressure to get the program operational and did not spend sufficient time identifying, educating, and involving stakeholders in the community.

One Partnership Program administrator reported that it would have been better to have worked on key community relationships in the beginning of their process rather than having to go back later and explain the program. They went on to say that often their organization had to "repair damage" that had occurred because of a misunderstanding or miscommunication about the intent of the Partnership Program, who it serves, and how it works.

Specific difficulties included lack of appropriate education about the Partnership Program and an overall misunderstanding about the length of time needed to complete financial eligibility and enroll consumers. This concern was compounded by the fact that the county government was an important source for referrals to the program. Both these functions—determining financial eligibility and making referrals—are critical when a Partnership program is just starting and needs to reach an enrollment threshold that will sustain the program. When county governments do not understand your program, are uncertain about eligibility requirements, and offer only a limited number of referrals, it will cost your Partnership program both necessary revenue and staff resources.

Voice of Experience

Partnership Program staff say it is better to "pave the way" for the Partnership Program through outreach, education, and community relations during the planning phase rather than to go back later to explain what you are trying to do. Ongoing community education makes a real difference in how well the program is understood and accepted in the community.

Wisconsin's Partnership Programs all emphasized the importance of identifying the key sources for referrals to the program and the need to spend the upfront time to build solid,

collaborative relationships. There needs to be a plan and commitment for on-going

education and communication between the Partnership staff and the persons they will be

working with from organizations providing referrals. Although one Partnership Program

did conduct consumer focus groups and had their Partnership staff working closely with

the long-term staff from the county, they believed more time should have been spent

educating and establishing relationships with other organizations in their community who

would be key referral sources for their program.

Voice of Experience

You will need to identify potential referrals several months before you start your program. Having a sufficient number of members to "jumpstart" your program is essential because the team needs enough members to learn to function as a care management unit and be effective for the member. Without enough referrals, the Partnership Team doesn't have enough to do and may develop work routines or expectations that are not compatible with higher caseloads or get assigned other duties. There are also serious financial implications to a slow start up.

There are many political boundaries to cross in an endeavor such as developing a

Partnership Program. One is the frequent division between health care programs and

community advocates. Consumer rights advocates often question the ability of health

care programs to maximize consumer choice and participation.

Partnership Program staff described how county government staff and members of the

advocacy community were suspicious of the Partnership Program as a managed care

program since such programs had a reputation of being unresponsive to consumers.

Advocates were understandably cautious about such an organization's ability to be

consumer centered. There was also a lack of understanding of how the Partnership

Program would work. Initially, many advocates and county workers believed the

program would be taking clients and funding away from, rather than adding resources to,

the community and the services available for these vulnerable populations. The

Partnership Programs were not prepared for this "anti" health care/managed care attitude.

While persons working with the Partnership Program understood they were not a

"typical" managed care organization, others in the community did not understand why

and how the Partnership Program was unique. The burden was on the Partnership

Program to demonstrate how exactly it would operate, how this would be different than

the way managed care organizations typically operated, and how consumers would

benefit.

Voice of Experience

Again, regular meetings with stakeholders to discuss the program, what it offers consumers, and how it can complement other community services are important. Partnership organizations found that it was difficult for other providers to really understand the Partnership program. They seemed to understand the concept initially but didn't really "get it" until they had the opportunity to see first hand how it made a difference in the life of someone they knew, whether family, friend, or mutual client. They needed proof, not just words. As the Partnership organizations grew and served more members, they established a reputation in the community and began getting complements and referrals from some of the early skeptics.

To accomplish this, two committees, the Community Steering Committee and the

Community Advisory Committee, played key roles in the development and

implementation of the Partnership Program.

See the chart on the following page that describes the three key internal and external

committees involved in the planning and implementation of Partnership.

There are three key committee structures that will assist organizations as they plan and implement a Partnership Program. This illustration shows the primary purpose of each respective committee, how membership and key activities relate to each other, when committees should begin, and how long committees should continue to meet.

Bi-weekly or Weekly

PLANNING COMMITTEE

The primary goals of the Planning Committee are to oversee the Partnership Program planning functions including assessment of the organization's infrastructure and capacity to develop this integrated model.

Members:
- Executive Director/CEO
- Finance
- Operations
- Information Systems
- Quality
- Service Delivery
- Marketing/Public Relations
- Medical Director
- Board of Directors Representative

Key Activities:
- Develop internal care delivery & administration policies & procedures
- Develop financial information systems
- Build care management teams
- Complete necessary contract with state
- Establish physician panel
- Identity provider network
- Secure contracts with service providers
- Building awareness & credibility in community

Timeframe:
- 24 months before enrollment

Monthly

COMMUNITY STEERING COMMITTEE

The Community Steering Committee will focus on several major objectives: building relationships with the community; identifying potential providers; actively participating in the planning process &community education; and building referral sources.

Members:
- Consumers
- Health Care Delivery Systems
- Long-term Care Providers
- Local Government
- Religious Organizations
- Not-for-Profit Service Providers
- Local Elected Officials

Key Activities:
- Identify providers, schedule introductory/education meeting
- Initiate contract for services
- Identify community physicians for participation in program
- Plan & sponsor community-wide education forums
- Identify & begin discussions with potential referral sources
- Conduct education sessions w/ hospital discharge personnel & key referral organizations
- Conduct workshops referral & enrollment process

Timeframe:
- 12-18 months before enrollment

4-6 times each year

COMMUNITY ADVISORY COMMITTEE

The role of the Community Advisory Committee is to provide ongoing oversight to the Partnership Program and key liaison activities

Members:
- Partnership Program Director
- Key Contracted Provider Organizations
- Local government
- Non-profit organizations
- Community Leaders
- Advocates
- Consumers

Key Activities:
- Ongoing community oversight of the Partnership Community
- Continue community education on program
- Discuss provider issues/problems & recommend action
- Discuss consumer satisfaction & give feedback to Partnership Director
- Continue to identify referrals
- Continue to identify needed service providers

Timeframe:
- Enrollment-ongoing

Key members of the Planning Committee may participate on the Community Steering Committee in an ongoing or as needed basis. The Planning Committee will work to establish the Steering Committee & provide needed staffing, information, & direction for the meetings. Planning Committee members will work interactively with the Community Steering Committee on program planning & implementation.

The overlap between the conclusion of the work of the Community Steering Committee and the ongoing Advisory Committee may be 4-6 months. Many members of the Steering Committee may choose to participate in the ongoing Advisory group. The focus of activities changes from launching the program to ongoing community involvement and oversight.

Community Steering Committee

An effective way to make certain you include key community stakeholders in your planning process is to organize a Partnership Program Community Steering Committee. Again, this needs to be done early in the process of development. This committee can help allay fears, create allies, and, more importantly, provide useful expertise for the developing Partnership Program such as identifying preferred providers and/or detailing the history of provider relationships. The purpose of the Community Steering Committee is to:

- Identify and educate potential service providers,

- Advise the Planning Committee in the development of a Partnership Program that meets the unique needs of its community,

- Begin to identify referrals, and

- Create community allies.

Voice of Experience

The process of convening a Community Steering Committee should begin at least one-year before the target date for enrollment.

Start by finding the right people to participate on the Community Steering Committee. Membership on the Steering Committee should be representative of the community and include persons who provide services (including voluntary) to the targeted population. Membership may include:

- Consumers,

- Health care providers,

- Long-term care providers (institution and community-based),

- Local government,

- Churches and religious orders,

- Not-for-profit providers or services such as hospice, personal care, and home health, and

- Representatives of large/powerful systems.

Be sure to include individuals who are positioned high enough in their organizations to bring authority and organizational commitment. You may also consider both local and state elected officials in the planning process, such as county commissioners and state representatives.

One caveat here is to find persons who can bring both expertise and credibility to the planning process. These individuals must be flexible, open to new ways of doing things and able to contribute to the development of the program and the organization. For example, in one community, a budding Partnership Program that hoped to serve a younger, disabled population invited a Rehabilitation Medicine specialist to serve on the Steering Committee. This particular physician often provided consultation to other physicians in the community who were caring for individuals with serious long-term disabilities. He was well known and well respected by the medical community and had already established a working relationship with many primary care providers in the local area. This had the effect of greatly reducing the work that would be required later to establish credibility and to create working relationships with providers. Bringing him into the planning process and letting him bring the message to colleagues in the community was an effective strategy for gaining credibility.

When forming the Steering Committee for the planning and development of a Partnership Program, it is also important to balance broad representation from the community with the need to have a manageable, working committee. The organization will need to commit adequate time and resources to the committee to assure follow-through. This may be the time to consider engaging an outside consultant who has professional experience, organizational skills, and time to adequately support the committee. The Steering Committee would likely meet two hours each month up until the program begins enrollment. Remember, you will be asking community professionals to give up their time to participate so make certain their time is used wisely.

Community Advisory Committee

In addition to the limited membership of the Steering Committee, you will need to form a broader group of local community leaders.   The Community Advisory Committee should be organized as the Community Steering Committee is concluding their planning process. By this time, the Partnership Program will be in place and enrollment will have begun.

While the Community Steering Committee will be involved in the actual planning of the program, the Community Advisory Committee will provide an ongoing forum for discussing questions, issues, or concerns about the Partnership Program. Its role is to establish a community presence for the Program by creating regular opportunities to

engage community members.   The Community Advisory Committee members will serve as advisors, ambassadors, and partners. They will meet with the Partnership director and staff to identify potential consumers, troubleshoot, and problem solve.

For example, one Partnership Program raised concerns about the length of time it took to access consumers' medical records. Because of its broad community representation, the Community Advisory Committee was able to discuss the problem and current process for accessing medical records, recommend possible solutions, and ultimately resolve the issue. Another Community Advisory Committee was able to address problems regarding an agency's unwillingness to provide weekend home health services. With key community members represented on the committee, this issue was resolved quickly.

Community Advisory Membership

Members might include representatives from consumer groups, the United Way, community foundations, Area Agencies on Aging, government officials and religious orders. The Community Steering Committee will be instrumental in identifying people for membership on the Community Advisory Committee whose support will be needed if a Partnership is to succeed.

Forming a Community Advisory Committee

One way to form a Community Advisory Committee is for the Community Steering Committee to sponsor a community-wide forum or event to describe the program and the impact it would have on the potential, targeted population and current service providers. This is a good way to accomplish a broad educational effort and begin to get a sense of the interest and commitment of the community. It is also a way to dispel myths and/or

rumors about what the Partnership Program will achieve or how it will operate. Some of the issues to address during this forum are:

1. Target population,

2. Problems you are trying to solve,

3. How the program will operate,

4. What makes it unique,

5. Issues of competition for resource or consumers,

6. How the program will add to rather than detract from what is currently available,

7. How the program may influence services provision patterns of existing program, and

8. How progress quality will be monitored.

Finally, it is important that these stakeholders all have a chance to express their concerns, make suggestions, have their voices heard, and see how their input may be reflected in the final structure. It is vital at this point to listen carefully and not become defensive.

One Partnership Program sponsored such an event. The Partnership Steering Committee, working with a local community hospital that had a representative on the committee, organized a community-wide meeting. The hospital provided a large room and refreshments for the event, and the Steering Committee developed the invitation list and gave state and local officials an opportunity to speak. The meeting was scheduled for two hours in the late afternoon, which allowed time for people to talk about the Partnership Program from a variety of perspectives. It also created an opportunity for questions and socializing. Press from the local paper attended the event, which resulted

in positive local press. The event was well received and succeeded in developing stronger community relationships and identifying potential members for the Community Advisory Committee.

Interaction Between Committees

As discussed in Chapter 8, the Planning Committee oversees all Partnership planning functions. To do this successfully, it needs to establish and then interact with the Community Steering Committee and the Community Advisory Committees. Because of the pivotal role of the Planning Committee, its membership needs to include members who represent key organizational functions including executive director/CEO, finance, operations, information systems, service delivery, quality improvement, and marketing/public relations.   Since the organization is still exploring program development, it may not have individuals on staff with these skill sets. However, these skills are needed both to present a credible "face" to the community and to appropriately analyze information gathered. Therefore, if the resources are not available to hire these individuals, the organization may need to use consultants for more time-limited activities.

It may be tempting to simply hire staff for these positions who have the lowest level of expertise needed, since they will be relatively inexpensive. Don't. Partnership sites that did this suffered in the long run because systems were not set up that could grow and respond to increasingly complex needs. For example, some Partnership sites hired bookkeepers instead of more sophisticated accountants or financial officers.   This also occurred at some sites with individuals hired to develop information systems.

Because Partnership is a sophisticated managed care program that assumes significant risk, the importance of hiring staff with the expertise and experience to manage complex systems and requirements, to gather and analyze sophisticated data, and to manage public relations cannot be overstated.

Voice of Experience

Data runs the "Partnership train." Programs should make it a priority to identify, collect, and analyze data early and accurately. This data will be used to develop internal operations, support quality, and inform reporting and how you approach the community. Designating members of the Planning Committee to this role is central to this effort.

Selecting the right Planning Committee and Steering Committee members will be important especially when you begin to meet and interact with community providers, introduce them to the Partnership Program, and discuss potential contracts for services. You will want to include key members of your Planning Committee, such as the executive director, financial officer, and someone familiar with the health and long-term care services, in most of these meetings.

It will also be helpful to include members of your Steering Committee in these introductory meetings. Representatives of the provider community will be serving on your Committee and may be able to set up the meeting with appropriate persons in their organization. This is one thing to think about when deciding whom to invite to participate on your Steering Committee.

For example, one Wisconsin Partnership Program had persons from each of the large health care delivery systems in their community represented on their Steering Committee. These members were able to identify the right persons to meet with in their respective organizations. They were insiders in their organizations and were aware of the concerns of the organizations and the individual players. They understood the structure of the organization, special interests, and knew the language used by insiders. The importance of cross-disciplinary and cross-organizational language differences should not be minimized since they can complicate negotiations if these things remain unclear. Steering Committee members will also be able to facilitate the timely scheduling of meetings and, most importantly, their participation gives recognition and credibility to the Partnership Program. Without their assistance and insights, it would be difficult to know exactly whom you should be meeting with and the best way to be prepared.

The purpose of these initial meetings with members of the Planning Committee, the Community Steering Committee, and community providers is to provide an overview of the program—who it serves, how it works, what role the service provider will play, and how the services will be reimbursed. Be sure you are clear on the answers to these questions yourselves and have discussed this at length among your Planning Committee members. When your Planning Committee meets with community providers, it is helpful to have printed materials that describe the program and who to contact for further information. These can be left with providers at your visits.

Developing a Service Network

Because Partnership Programs arrange for, oversee, and/or provide the entire gamut of their members' health and long-term care needs, an extensive service network will be necessary from the first day of enrollment. This can be a major challenge for a community based social service organization because it will catapult staff into the world of hospitals, medicine and doctors. The nurse practitioner and other nursing staff can be quite helpful in these conversations and negotiations. They will be knowledgeable about the issues, will speak the language and will bring important credibility to the process. The same wisdom applies when negotiating with social service and long-term support systems. Seasoned social workers can assist health care providers in using 'the right' language and being sensitive to the concerns of this provider group.

The challenge for Partnership Programs is not only to have contracts in place for all required health and long-term care services but also, to make certain that contracted providers perform as an integrated network. In large part, the Partnership team will coordinate and manage services. However, the contracted providers will also be expected to understand the unique requirements for delivering their services within a Partnership model, to have effective communication systems in order to insure that the Partnership team can coordinate all aspects of care, and to maintain good working relationships with other providers in the network to insure continued cooperation. These functions are vital to maintain the integrated operation of the program. Initial networking builds good will and credibility with community providers and determines what services will and will not be available. This has important implications for the evolution of the program since, any services that are not available, not reliable, or not of high enough quality will have to be

developed or provided by the Partnership organization itself.   These networking

activities provide important information for the team and the contract specialist regarding

service quality and availability in the community.

Network Service Providers

The Internal Planning Committee will be gathering important information about how

other service providers view their role, their ability to cooperate and the compatibility of

their services with the Partnership philosophy. Some of the service providers that the

Partnership Planning team will want to make contact with are:

- Health Care Systems (hospitals and clinics)

- Specific Goods and Services providers – Many of these goods and services
  may be available through and/or embedded in a larger Health Care System
  such as:
  - o Home health,
  - o Social services (personal care, housekeeping, Meals on
    Wheels),

  - o Mental health,
  - o Hospice,
  - o Durable medical equipment,
  - o Physical/Occupational therapy,
  - o Laboratory,
  - o Podiatry,
  - o Dentistry,
  - o Pharmacy,
  - o Transportation, and
  - o Complimentary care providers (such as massage
    therapists).
- Residential Care:

  - o Nursing homes,
  - o Assisted living facilities, and
  - o Residential hospice centers.

Your first step in developing your service provider network is to clearly identify all of the services you will need to provide to program members. The list above was constructed with input from both consumers and providers. Your needs may vary depending on the group you are serving. (See Appendix S for a description of key service providers).

Voice of Experience

Since no two communities are alike, Partnership Programs found it very helpful to have their Planning Committees work with their Steering Committees to develop comprehensive service grids (See Appendix T). The Planning Committee listed all needed services and Steering Committee members identified potential vendors and provided information about a) who currently uses which vendors, b) relationships among vendors, and c) perceived quality of vendors' services.

Determine who is currently providing which services to the potential population, how those services are organized and managed, and the quality of each service provider. Meet with these providers to learn how services are delivered and perceptions of both service quality and gaps in the community.   Discuss the Partnership Program concept with them and determine their interests and/or concerns about Partnership as well as their concerns about their current business. It is important to know which local providers would see Partnership as a benefit to the community and/or a compliment to their services and which, if any, would consider Partnership to be a competitor.

For example, in each Partnership community where a Hospice program was already established, the Partnership staff found themselves in a politically sensitive situation. Hospice has a long history of providing high quality end-of-life care and often claim this

territory as their sole domain. Tension can be created between Partnership and Hospice when the Partnership Program continues to serve consumers at the end of their lives.

Other Partnership organizations found that home health agencies and nursing homes felt that the Partnership agency was competing with them for consumers. To address these issues, some current providers may become partners or subcontractors to a Partnership Program. In fact, subcontracting agreements can turn potential competitors into effective collaborators. Ongoing communication is critical and a "call me with any concerns" attitude can keep little problems from turning into crises.

Voice of Experience

The key is to addressing potential tension between programs is to appreciate the expertise that each brings and to keep the member's best interest in mind. Often the source of conflict lies in the restrictions imposed by regulations, especially related to both programs receiving federal funding and whether or not services can be unbundled, or, in other words, purchased separately rather than the member being transferred from one program to the other.

Partnership teams often become very close to their members and know them and their unique needs very well. For example, when Partnership staff are educated about end of life care, they can meet the member's needs while maintaining the continuity and trusting relationships that the member values. For members whose needs are more complex and who have limited informal supports, a referral to Hospice can be very helpful. Discussions need to occur between the two organizations on how to work collaboratively and to resolve payment issues.

There are several things that should be determined about each provider early in negotiations.   Important qualities are:

1. Whether providers who are currently Medicaid certified are willing to continue to serve Medicaid eligible persons,

2. Whether a provider has an office and/or facility that is accessible for persons who may be in a wheelchair or have difficulty negotiating stairs or other barriers,

3. How providers will share information,

4. How providers will collaborate with the interdisciplinary team (IDT), and

5. How providers will notify Partnership.

You will also need to estimate the amount of services that will be needed by consumers and arrange service provision systems that they will meet the unique service needs of the Partnership Program. For example, contracted pharmacies may need to deliver medications to a member's residence, and home health or personal care organizations may need to provide services seven days a week. It is vital that these requirements are made clear from the beginning. Many providers you contract with may not be accustomed to working in this way. Find out whether potential providers are willing to adapt. If they cannot, you may need to plan for supplementing their services or finding other providers. Explore in some detail the strategies they will use to develop the services or capacity they do not already have and the level of responsiveness they will need. It is also important that you have a good understanding of what is in it for them. Be clear about what they think they will gain. Think about how your proposal will help meet some of *their* organizational needs. This of course requires some understanding of the businesses you will be negotiating with and what their challenges and concerns are. Once again, your Steering Committee will be able to help you with this if you have organized it well.

Whenever possible, find more than one provider for key services. When faced with the challenging task of negotiating, establishing, and monitoring provider contracts it might be tempting to contract with only one provider of each service type. This is unwise because a limited number of providers impacts both consumer choice and system capacity/responsiveness.

Take advantage of natural relationships to provide a wide network of providers for consumers to choose from. Contracting with networks or natural groupings of providers reduces the work and greatly increases the network capacity and consumer choice. For example, a chain of pharmacies will honor the same contract, provide the same level of service, and, perhaps, use the same software. The member can then use the one closest to their home. Contracting with a clinic or group of providers versus a single provider ensures coverage during vacations, better access, and involves only one contract.

The chances of overwhelming a service provider's capacity to serve Partnership members adequately and to respond quickly to member needs, is also reduced by having multiple providers available. Many of the providers you will be contracting with have been able to reject or delay a referral when it is not convenient to accept it or when their resources were inadequate. Establishing expectations about response time is important but there will still be times when a contracted provider is unable to take a referral. Having back up from other providers in the network, who also understand and can work with the Partnership system will be essential on those occasions. A provider organization could also go out of business suddenly, leaving members without important services if there are no readily available alternatives. It is also important for consumers to have choices about

which providers they are comfortable with. Partnership physicians will also have preferences in providers they work with. This is only possible with a range of providers to select from.

Some geographic dispersion of providers is also important to maintain easy access for consumers. Single providers or centralized services, while more convenient for the staff, might make it difficult for consumers to obtain services that are close to their homes. This could be a major deterrent to consumers and is a frequent source of dissatisfaction for most consumer groups. Consumer satisfaction surveys repeatedly demonstrate that long rides to service providers, especially with multiple stops, is a predictable source of consumer dissatisfaction. The difficulty of developing and operating reliable transportation services should not be minimized. Across the board, Partnership Programs agreed that providing sufficient, flexible, non-emergency transportation was a critical concern, whether they were contracting with an existing agency or building the internal capacity on their own.

One WPP agency requested and received grants to help defray costs of purchasing fleet vehicles. In addition to vehicle maintenance and meeting carrier regulations, the agency needs to ensure that drivers are CDL certified and complete additional training pertinent to the special needs of the population. Recruitment, hiring, and dealing with turnover and other staff issues need to be addressed. Scheduling and dispatching are essential components of operating the service.

Another equally complex concern was the provision of On-Call Services. Partnership Programs had to establish a 24-hour On-Call phone number to address a range of health

care issues, hire staff to answer calls, triage consumers, and make appropriate referrals. Like transportation, developing On-Call services required significant time and investment.

Finally, a truly consumer centered program must consider consumer choice and fit with services.   Each provider conducts business differently, has at least a slightly different range of services and products than others offer, and employs a specific group of workers. There may be important issues of fit or match between these things and a consumer's needs and/or preferences.   Consumer concerns may be about scheduling, staff skills/personalities and/or, important product differences such as with DME. When serving a population with a high level of physical disability, what seems like a minor difference to providers can be a major quality of life issue for consumers. It is vital to be sensitive to this and to plan accordingly.

Voice of Experience

Setting limits that are primarily for the convenience of the staff and the program can significantly undermine the ability of the program to be consumer centered. Some examples of issues that are extremely important to consumers include: seating choices for wheelchairs, availability of personal care workers at certain hours, availability of van transportation service to certain sections of the city, proximity of provider to other services needed, proximity to bus routes, closeness to friends and relatives who can help, familiarity with staff, and many more

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Approaching Community Providers

In key provider systems, identify someone who could act as a champion or advocate for the Partnership Program. Provide potential partners with additional information about the

Partnership Program and explore how such a program might work in your community. This manual may be a helpful resource for this, as would materials on the Wisconsin Health and Family Services Partnership web site (www.dhfs.state.wi.us/WIpartnership/). Identify those providers who may be willing to work with you and determine their interest in conducting a full feasibility study with you.

Voice of Experience

It may be tempting to team up with providers who are ideologically sympathetic with the program's aspirations and are seen, or see themselves, as radicals. While there may be a greater sense of comfort with these people, and they may appear to be a better fit, they may actually be quite marginal in the medical community and could damage your organization's credibility at a very sensitive time. In more than one of the Partnership sites, this sort of person was the first to come forward and offer to participate. Finding out who you need on your team and approaching them is a much better strategy than waiting for the "right" providers to approach you.

When you are preparing to meet with potential providers using the following list will make certain you fully explain the advantages of contracting with a Partnership Program and the questions or issues you will want to explore. These include:

- Partnership provides more flexibility in providing preventative care as well as the usual medical and emergency care routinely covered by Medicaid and Medicare.

- Services are better coordinated.

- Care decisions are made locally and quickly, which eliminates the delay of approval of proposed care or payment due to processing paperwork elsewhere.

- Providers are able to work with only one local contact point regarding service questions, authorization or billing. However, providers will need

to know how to recognize a Partnership Program enrollee and be clear on how to bill for services.

- Team members who have a thorough knowledge of a personal relationship with challenging members can assist the provider in difficult times.

Also be sure to explore the following issues/topics with potential partners and contractors:

- What is the provider's definition of "success" with a patient/client/member? How well does this definition fit with the Partnership philosophy of consumer-centered care and the realities of providing care under a capitated financial system?

- Is the provider clear that this is a preliminary assessment for a new program? This means a full feasibility study is still needed and, even if the decision is made to go ahead with the Partnership Program, it will be a long time before members will be enrolled.

- Does the provider understand that its legal relationship would be with the Partnership organization, not individual members? This means that members are legally "held harmless" and cannot be billed for any "unpaid balance" after payment is received from the Partnership organization.

- Would the provider be willing to share risk through a sub-capitation contract?

A final note on establishing a service network is to determine when and why there are gaps in needed services. When gaps in service are identified, it is very important to determine if these are due to a lack of service coordination or an actual lack of providers. The care management component of the Partnership Program can address problems with service coordination.   However, if a gap in service is due to a lack of providers or an insufficient number of providers, a Partnership Program would need to develop the internal capacity to deliver such a service. For example, if public or private transportation services are limited or unreliable, a Partnership Program may need to include development of its own system in its plans.

Partnership Payment Processes

In Wisconsin, the Partnership Programs are paid prospectively the last week of the month for services the following month. There is a monthly reconciliation between the state and the Partnership Program to compare clients on the state's list to the actual clients being served. This system allows for a better cash flow for the Partnership Program The Partnership Programs also receive a monthly payment from the federal government for members eligible for Medicare. The programs report that working with the federal government for the Medicare capitation requires a great deal of paper work, however, there are plans to perform these functions electronically in the future.

It is also important to fully understand the necessary process to determine if a person is eligible for the Partnership Program and, the exact date the program will be responsible for care and payment for services. In Wisconsin, the county government is responsible for initial determination of Medicaid eligibility, the state government approves or disapproves the determination and makes the capitated Medicaid payment to the Partnership Program. There may be several steps in the process of determination of eligibility and appropriate capitated, monthly payments. Make certain that you have included language in your contract with the State clearly outlining the process, roles and responsibilities of the Partnership Program.

This clarity can help ease the administrative transition involved in member enrollment later. This, in turn, will speed payments to the Partnership Program, which is always important for cash flow.

Environmental Scan

When meeting with stakeholders, providers, state agency representatives and others in the community, discuss their perceptions of broader trends and forecasts that could influence the success of a Partnership Program. For example, it would be important to know if the number of providers has been increasing or decreasing, if the demographics of the expected population to be served is changing, or if a large for-profit health care organization is planning to expand into the area.

Decision Point

The "Preliminary External Assessment and Relationship-building Checklist" can help an organization decide if its environment is conducive to the development of a Partnership Program and the cost of a full feasibility study is justified. This tool considers both current capacity (who does what) and potential support for the program.

Preliminary External Assessment and Relationship-building Checklist

		Not Sure	No	Yes
1.	All state entities that could regulate or influence the development of a Partnership Program have been identified.	☐	☐	☐
2.	These state entities have articulated what they would require of a Partnership Program.	☐	☐	☐
3.	These state entities have articulated the criteria that would be used to judge the success of the program.	☐	☐	☐
4.	These state entities have indicated that they have the capacity and willingness to provide information about the service population and estimates on the cost of care.	☐	☐	☐
5.	The number of potential members of the Partnership Program has been determined.	☐	☐	☐
6.	The government entity that currently administers fee-for-service payments for potential members has been identified.	☐	☐	☐
7.	The government entity that currently administers fee-for-service payments for potential members has indicated a willingness to work cooperatively with a Partnership Program.	☐	☐	☐
8.	Community stakeholders have been identified.	☐	☐	☐
9.	Community stakeholders have indicated a willingness to support (or, at least, not block) the development of a Partnership Program.	☐	☐	☐
10.	Current service providers have been identified and consulted on the development of a Partnership Program.	☐	☐	☐
11.	Influential individuals within key provider organizations will advocate for the development of a Partnership Program.	☐	☐	☐
12.	Potential partners and contractors have been identified.	☐	☐	☐
13.	Potential partners and contractors understand how a Partnership Program works.	☐	☐	☐
14.	Perceived gaps in the service network have been identified.	☐	☐	☐
15.	It has been determined whether gaps in service are due to lack of coordination or limited providers.	☐	☐	☐
16.	Major trends and forecasts in service provision have been identified.	☐	☐	☐

Understanding the Results

The following are general guidelines for interpreting the results of the Preliminary

External Assessment and Relationship-building Checklist.

- Any question answered "Not Sure" indicates a need for further research in that area.

- Questions 1-7 refer to government entities, their requirements, their ability to provide information, and their enthusiasm for the program. A "No" response to any of these questions suggests further work be done in this area before proceeding with a full feasibility study.

- Questions 8 and 9 refer to community stakeholders who may or may not hold formal roles in the community. These individuals and their opinions of Partnership need to be identified. If any of these stakeholders do not support or actively oppose the development of a Partnership Program, then their objections and the strength of their influence will need to be assessed. Explore the reasons behind the concerns. They may indicate ways in which the program would need to be shaped to fit the community, or that a new, spun-off organization may need to be created to deliver services. If a powerful stakeholder opposes the program for philosophical reasons, then consider the likelihood of success without this stakeholder's support. It may be best not to proceed at this time.

- Questions 10-15 consider the present service network in the community and its receptivity to working with a Partnership Program. If current providers do not see a need for and/or are not open to working with the program, then it is unlikely to succeed. The information needed to answer Question 15 ("It has been determined whether gaps in service are due to lack of coordination or limited providers.") is especially important for business planning. If gaps in service are primarily due to a lack of providers, then a Partnership Program would need to develop, rather than contract for, many of these.

- Question 16 refers to changes occurring in the general environment that could influence business planning.

Chapter 10
Steps to Program Adoption:
Full Feasibility Study

Introduction

After you have successfully completed the pre-feasibility study, you are ready to embark on a full feasibility study. A full feasibility study includes a great deal of research and financial analysis. The organization's specific needs for capacity building, the consumers to be served and the state's specific support of the program must all be considered. This may be time to consider using a consultant's services to assist in key areas where your organization may not have expertise and/or it may not be cost-effective to build internal expertise (See Appendix B).

Internal Feasibility

The internal aspect of a feasibility study entails developing a business plan and financial projections. Before doing so, however, the organization should be very clear about the underlying assumptions of the program. If it undertakes this endeavor, it will be taking on responsibility for a population that will have high needs for care and, therefore, present significant financial risk. This means the organization must be prepared to serve a small population of members who will be in constant need of an array of multiple services. Therefore, unlike other traditional managed care organizations, the cost of providing those services cannot be spread over a large pool of members—a percentage of whom will use a limited number of low cost services. To be sure there is a full understanding of the financial risks of serving a small, targeted population of persons

with multiple health and support needs, it is recommended the board pass a resolution to this effect when it commits the resources for the feasibility study.

This is also the time to do a thorough and honest assessment of the organization's strengths and weaknesses, since these will impact the feasibility of developing a successful program. You will need to explicitly plan how to protect and leverage your strengths while minimizing the impact of your weaknesses. A consultant may be helpful in conducting this evaluation.

The organization must develop a business plan for the Partnership Program. This plan will describe the program as envisioned, the increased capacity needed, and the projected financial needs and revenues. The business plan will not only help organize and adequately plan for the growth of the program, but will serve as marketing information when searching for start-up funds.

The basic steps in this plan development are as follows:

- Review capacity and program development needs described in the next section of this manual – scenario planning at different level,

- Compare needs with current capacity,

- Sequence development steps, based on current capacity and development sequence recommendations in this manual,

- Create a timeline for development,

- Assign costs (prepare financial pro forma),

- Identify the target date for enrollment,

- Project the rate of monthly enrollment and the time it will take to reach projected enrollment, and

- Identify the break-even point, which is the number of members needed to cover operating expenses *and* make up for development costs that were incurred before members were enrolled. (Sample financial planning formats are included in Appendix U).

Community Feasibility

During the pre-feasibility phase, the organization should have gathered basic information on the population to be served and the existing service network.   At this point, far more detailed information is needed. The goal is to create a "snapshot" of the community that identifies:

- The number and location of potential members

- The number, location, type and volume of current service providers

- Availability of other resources needed for the program.

- Any service providers serving large numbers of target populations

You need to identify your potential market of members and try to determine the types of services they are currently using. It may be useful to draw a map of where potential members may be living (private homes, residential care, independent apartments, nursing homes) and the provider community (hospitals, physician clinics, day centers). This may also help identify gaps in key services such as home health, personal care and transportation (See Appendix S for an sample map).

During the pre-feasibility external assessment, general information was gathered on providers, perceived service needs and payment systems. Now is the time to gather very specific information in these areas.

There are several goals at this point. One is to identify an initial group of potential

members and examine timelines for enrollment and payment for care.   This will be the

first of several projections you will make to determine how much time it will take your

organization to cover your costs of operation. This initial projection will be adjusted as

you gather more information.   As you make these projections, it will be very important

for you to talk with a consultant or have staff on hand who have knowledge about risk-

based financial modeling (See Appendix V for CCO/CCE's Financial Planning Format).

Another goal is to identify the availability of other resources needed for the program.

Financial resources are important, but so are human resources. A labor market analysis

may be needed to determine the local availability and pay scales of certain professionals.

An organization may want to talk with area providers about their experience in recruiting,

and retaining, health care and other professionals. You will need to plan to have

sufficient time to hire and train key Partnership staff.

In order to achieve the above goals, you need to:

- Develop a comprehensive list of all the services needed to fully support the Partnership Program such as dentistry, home health, and transportation;

- Identify community providers by service type i.e.; clinics, hospitals, nursing homes, Community Based Residential Facilities (CBRF), primary care physicians, specialists, mental health providers, chiropractors, dentists, podiatrists, physical and occupational therapy, etc;

- Indicate the size and capacity of each provider (For example, can the local home health agency serve 200 persons or 60?);

- Identify the costs or rates for services;

- Identify the reimbursement sources (i.e. private pay, Medicare, Medicaid)

- Identify which providers are/are not accepting new patients/clients;

- Identify which providers may have limited or exclusive services;

- Determine which providers serve a significant number of persons who may be potential members of the program;

- Determine which providers would be potential referral sources for the Partnership Program;

- Determine the process and length of time it would take to identify potentially eligible members, determine if they meet the enrollment criteria and are interested in the program, and enroll them into the Partnership Program;

- Determine if identified providers would be willing to enter into a Contract for Services with the Partnership Program; and

- Determine if identified providers meet the quality measures/standards necessary for the Partnership Program.

Voice of Experience

Many Partnership Programs organizations found that local shortages of nurses and personal care assistants caused unexpected problems in recruitment and a need to adjust pay scales.

State Relationship

The state is a major stakeholder in a Partnership Program and it has been said that Partnership organizations "live and die by their contractual agreement with the state" (See Appendix W for a Sample Contract). The Wisconsin Partnership organizations have several suggestions to help make this relationship productive for all participants.

Contact Person

Although on paper the partnership exists between organizations and government entities, problem solving, negotiations and communications occur between individuals. If communication occurs between different individuals from the Partnership organization and state agencies, or if people involved leave or change positions, confusion and lost opportunities are likely. Therefore, organizations should ask for, and the state should designate, a single point of contact for the program. This contact person should have enough authority within the state agency to adjust the administrative demands placed on the program (particularly while an administrative support system is being developed). The designated contact person should also be knowledgeable about and willing to work with the federal Centers for Medicare and Medicaid Services.

Contract

Wisconsin Partnership organizations enter into a Medicaid managed care contract with the Wisconsin Department of Health and Family Services (DHFS) and operate under waiver authority from the federal Centers for Medicare and Medicaid Services (CMS). The DHFS applies for the waiver authority that allows the Partnership Programs to provide integrated health and long-term care services to program participants through a capitated Medicare and Medicaid payment. It is important for the contact person at the state, the Partnership organization, and CMS representatives to understand and acknowledge all of the regulatory and reporting requirements for the program, and to determine when federal authority will supersede state requirements.

Content of the Contract

Partnership organizations must have a full understanding of the content and requirements of the State contract. The contracts between the state and Partnership organizations are comprehensive and complex legal documents that will clearly delineate the responsibilities and requirements of the Partnership organizations. This type of managed health care contract for government payer populations may be unfamiliar to organizations that have previously been providers of only social services. Key elements to consider are:

- **Capitation Rate**

  This is the amount of funding an organization will be paid by the state/federal government per member per month (PMPM). The payment amount(s), multiplied by the member months, will be the revenue amount needed to begin to determine the financial feasibility of the program. This amount, projected level of enrollment, expected payments for all needed contracted services, and the estimated cost of staff, infrastructure, and administrative support will be used to determine the "break-even" point for the organization. (Issues associated with determining the capitation rate will be discussed below.)

- **Risk Sharing**

  The Partnership Program is described as covering all costs of care and bearing financial risk for its members. In the first year or two of operation, however, an organization may negotiate an arrangement with the state to keep certain, high cost services, such as hospitalization, "carved out" of the capitation rate

and kept in the fee-for-service system.   These arrangements are often referred to as "risk corridors." This type of arrangement allows organizations that do not have experience in the delivery of health care services, and are entering a capitated, risk arrangement for the first time, the opportunity to expand their enrollment, establish their infrastructure, and collect necessary utilization data for effective financial planning. In Wisconsin, the Partnership organizations and the State fashioned an agreement that discouraged the programs from cost shifting to the carved out services and created financial incentives for the programs to manage the care effectively, thus avoiding the need for these high cost services. Be sure your organization has staff with expertise on risk sharing, and, if possible, strive to draft very clear expectations in your risk sharing arrangements.

Wisconsin's experience with risk sharing arrangements allowed sufficient time for the Partnership Programs to receive dual capitation (both Medicaid and Medicare) and to gradually take full risk for their members. When designing risk sharing agreements, make certain the arrangement is:

1. Not too complicated,

2. Clearly understood by both parties, and

3. Will not require verification data that may be difficult and time consuming to obtain and cause potential dispute between the risk-sharing partners.

Developing Contract Definitions

- **Eligibility and Payments for Enrollments and Disenrollments**

  The contract with the state needs to clearly define the criteria for determining member eligibility and outline the conditions under which an organization could disenroll a member. Information about enrollment and disenrollment criteria can be found in Section VII in the sample contract in Appendix W and in the Partnership Disenrollment/Enrollment protocol in Appendix X.

  The contract should also describe when the Partnership organization will receive a reimbursement payment in relationship to the day of the month a member is enrolled or disenrolled. For example, if a member enrolls in the middle of the month, will the organization receive a full or partial payment for that month, or will no payment be received for that member until the first full month of membership? The contract needs to define the specific events or procedures that need to take place in order to receive payment.

- **Evaluation Criteria**

  One of the innovative aspects of the Partnership Program is its focus on member-defined outcomes. Therefore, appropriate outcome indicators, such as satisfaction with providers, feeling that their needs are understood and being treated with respect, need to be developed to replace simple process indicators, such as frequency of team visits or diagnostic testing, for evaluating the program's success. Since it is a new program, it is likely that

state agencies will not have developed outcomes for this type of program and may, therefore, tend to rely on existing process indicators or on easily quantified, but not necessarily relevant, outcome indicators.

For example, at one time it was proposed that Wisconsin Partnership Programs provide a regular accounting of the number of each members' teeth. Although it could be argued that this is an indicator of health, it was not tied to the larger goals of the program. In this situation, an appropriate outcome, not process indicator, would be percent of members receiving dental cleanings and examinations. Inappropriate measures are not only time-consuming and burdensome for the Partnership organization, but they may also be intrusive to the members. It is recommended that Partnership organizations work closely with State officials in the development, testing and implementation of effective, consumer-centered outcomes for the program.

- **Rate Development Methodology**

  Partnership organizations need to have a complete understanding of the information and methodology the State uses to determine their Medicaid reimbursement rates. States may have experience in the development of Medicaid managed care reimbursement rates for acute and primary services, but have limited or no experience in development of capitated rates for long-term care services. Partnership organizations will want to make certain that states contract with outside actuaries to assure that the proposed

reimbursement rates have been analyzed. Many reimbursement methodologies will first determine the fee-for-service equivalent cost for the target population, make appropriate adjustments, provide any trending factors and, ultimately, determine the per member, per month reimbursement rates.

States will require that their Medicaid managed care programs, such as Partnership, be "budget neutral." In other words, the payment to the managed care organization cannot exceed what the state projects it would have paid for services for the same population over the same period of time under a fee for service system. Most states will want to achieve some savings in their managed care programs over what they would have spent in fee-for-service programs. Wisconsin takes their discount (5%) from the determined reimbursement rate before payment is made to the Partnership Programs, thus guaranteeing their savings and putting all the risk on the managed care programs.

- **Annual Reconciliation**

    Since payments are made to Partnership organizations based on projected Per Member Per Month costs, the state contract should include a provision for an annual reconciliation when payment adjustments are made with the organizations based on actual member data such as age, gender, and level of care needed.

- **Sharing Data with the State and Federal Governments**

  Data collection is an important component of Partnership programs, so potential programs will need to consider the cost of staff time and the development of adequate information systems in their financial planning. Data that need to be collected and analyzed include health and social service encounters (See Appendix Y for a complete list). It is imperative to have a full and complete understanding of the data that will be required to comply with the state contract and federal requirements. It will be expensive - both financially and programmatically—to miss reporting deadlines and/or to have to recreate data that was not captured at the appropriate time.

  Partnership organizations must work closely with all state agencies that may have regulatory or management oversight of the program to fully understand reporting requirements, including the exact data and report format needed before the program is launched. This will allow Partnership organizations to make certain they have the information systems in place at the program's inception to capture and report the necessary data. Please note that the Federal Centers for Medicare and Medicaid Services may have separate, additional data needs. (See Appendix Y for examples of data required for reports in Wisconsin.)

  The organization will also need to identify what data will be from the state and/or federal government. If reports are filed, will summaries be returned?

Will government reimbursement data be readily available? This data is useful for internal quality review and benchmarking purposes.

Since the Partnership will be a new program in your area, it may not be possible to identify all required data in advance. However, it must be made clear that data collection is a cost of doing business that must be planned for. Unexpected requests divert resources from member care to administrative expense.

Decision Point

The following checklist can be used to help determine if your organization is ready to commit resources to developing a Partnership Program.

		Not Sure	No	Yes
	Full Feasibility Checklist			
1.	The organization and its board have a clear understanding of the financial risk of serving a small number of persons with multiple health and support needs, as evidenced by a board resolution stating so.	☐	☐	☐
2.	The organization has completed a thorough assessment of its strengths and weaknesses and has a plan in place to minimize weaknesses.	☐	☐	☐
3.	The organization has completed a comprehensive study of the population of persons to be served, where these individuals live, how and from whom they currently receive health and support services.	☐	☐	☐
4.	The organization has identified sufficient service providers willing to contract and/or has plans to develop services where deficiencies exist.	☐	☐	☐
5.	The organization has full understanding of all of the requirements in their contract with the state including: the reimbursement rate they will receive; any risk adjustment or risk corridor arrangements and; federal requirements.	☐	☐	☐
6.	The organization has developed a business plan for the Partnership Program that includes key financial information and projections and staffing projections.	☐	☐	☐
7.	The organization has confidence in its business plan and projections for the Partnership Program, as evidenced by a board resolution stating so.	☐	☐	☐
8.	The State has clearly indicated its support for the development of a Partnership Program and has assigned a key staff person to work with the organization.	☐	☐	☐

Understanding the Results

An organization should not begin a Partnership program until it can confidently answer "Yes" to each of the above questions. Questions 1-7 address issues that are largely under the control of the organization. If any of these are answered with a "No" or "Not Sure," then efforts can be made to improve in these areas. If Question 8 is answered with a "No" or "Not Sure," then the organization should seriously consider postponing program development until the State has explicitly indicated this level of support, since program success is unlikely without it.

Chapter 11
Steps to Program Adoption:
Capacity Development

Introduction

Wisconsin Partnership providers had to develop new internal and external capacities to conduct the program. One organization that was already a PACE provider had more of the needed systems in place than the others, but it still needed to form new types of teams and build a medical panel of physicians. Similarly, a new Partnership Program's capacity development priorities will depend on what it already has in place. The following sections describe what is ultimately needed and suggest strategies for managing this growth.

Internal Capacity Development

Many of those involved in Wisconsin's Partnership start-ups say that, in the beginning, they were primarily focused on getting the program components in operation because these were what their members experienced and the community saw. They usually turned their attention to internal system development only when urgency, such as unpaid bills or an expensive medical procedure, demanded it. Some jokingly refer to their early capacity development as a version of administrative triage – and don't recommend it.

Voice of Experience

Once the Program's doors are open, the focus of activities shifts to growing and supporting the care management teams, maintaining relationships with community providers, and enrolling members. This is not the time to begin developing internal systems

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Unfortunately, an element of panicked infrastructure development may be inevitable in a rapidly growing organization. To minimize it, carefully consider the organizational capacity needs described below, compare these to your organizations' current situation, and plan accordingly.

Management

A successful Partnership Program needs managers who can link clinical and administrative functions. It also needs access to specialized skills in health care, financial planning, operations design, information technology, quality improvement and team development.

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Voice of Experience

Founders of the Wisconsin Partnership Programs recommend that start-up programs:

- **Hire managers with skills in health care finance early – before you think you can afford them because you can't afford NOT to have them**
- **Hire managers who can carry out several functions and are comfortable multi-tasking since, in the beginning, there will be a relatively small management team and "everyone needs to do some of everything"**
- **Hire managers who can make quick decisions and adjust to rapidly changing situations**
- **Hire managers who can operate effectively in a team environment,**
- **Contract for technical assistance in the areas you don't have expertise.**

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Information Systems

Partnership programs have complex information system needs. None of the current Wisconsin organizations is completely satisfied with its system. To some extent, this is because the programs continue to grow and the systems need continual upgrading.

However, it is also due to the fact that Partnership is a comprehensive, fully-integrated managed care program. The organizations require a sophisticated infrastructure to support their business and financial functions, such as payment for contracted services, case management efforts and risk management. The Partnership Programs all reported that it is essential to acquire or build adequate information systems early in the development process. Such a system must be able to provide data for:

- Day-to-day operations, such as scheduling transportation and personal care worker's time,

- Organizational financial functions and business planning,

- State and federal contract reporting requirements,

- Information and support for team case management,

- Medical record,

- Managing the comprehensive care needs of individual members, and

- Managing the financial risk of the organization.

Therefore, in addition to financial management software, Partnership Programs also need software for case management and scheduling. Identifying software to meet these needs can be problematic. In fact, three of the Partnership Programs collaborated to have Partnership-specific case management software program developed (Visual Prime). The larger challenge, however, has been and continues to be integrating information from these various software programs. For example, the scheduling of personal care workers with members is not easily linked to case management or financial management programs. Therefore, the systems in place cannot produce some of the reports that are needed for monitoring and decision-making. Complicating the situation further is the

fact that reports from the third party administrators, which are managing and paying claims, also cannot be linked to internal systems.

Without a fully integrated software system, Partnership managers have needed to manually input data from the existing systems into a report-writing program such as Excel in order get the reports needed.

A system is needed that provides information on the following:

- **Utilization Trend Reports**

  o *Utilization Management should include:*
    - Prior authorizations
    - Concurrent review requirements, such as hospitalization and routine services
    - Retrospective reviews to assess:
      - Accuracy of prospective review information;
      - Effectiveness of screening and risk assessment;
      - Necessity and quality of services provided;
      - Validity of review determinations and authorizations;
      - Potential areas for future prospective and concurrent reviews;
      - Modifications to clinical and administrative policies or protocols.

  o *Retrospective reviews should pay particular attention to:*
    - Invasive medical procedures;
    - Premature hospital discharges;
    - Emergency services;
    - Preventable admissions, incidents, illnesses or injuries;
    - Quality and reliability of delivered services;
    - Hospital admissions among nursing home residents
    - High cost medication or DME use

Financial Systems

Partnership programs are financially complex and organizations need to have systems in place to track data and provide information for managerial decision-making and external reporting.   This manual cannot provide specific directions for setting up your accounting system, but will summarize the basics elements it should have and the reports it should produce.

Financial Manager

Most essential to your financial system is a skilled finance manager. Each Partnership Program acknowledges having made the mistake of not hiring someone with an adequate level of expertise. They initially hired bookkeepers because it seemed fiscally wise. However, bookkeepers cannot create the financial and accounting infrastructure needed to grow the program and keep track of the complicated payment systems. In each instance, serious problems arose, the system had to be dismantled, and a new one put in place.

Voice of Experience

Several Partnership Program administrators suggest that, in addition to sophisticated financial skills, the Partnership financial officer should have experience with reimbursement in health care settings. At the very least, this should include a thorough understanding of Medicare and Medicaid reimbursement.

System Requirements

Since program expenses and their associated payments are not likely to occur in the same accounting period, at a minimum you will need an accrual, rather than cash, based

accounting system. In an accrual system, income and expenses are recorded as they are earned or incurred, not when received or paid out. In other words, to the extent possible, expenses are matched to their associated income, and expenses are tracked separately from cash flow. An accrual system also assumes that equipment is "used up" at a set rate and considers each increment of use as an expense (depreciation), even if no visible bill is paid.

One category of expenses that can be particularly problematic for a Partnership organization is Incurred But Not Reported (IBNR) costs. These are costs for which the organization is responsible, such as member hospitalizations, but have not yet received a bill. Since the goal is to match these expenses to income within the month(s) they occur, they must be estimated. This can be done using a Lag report. An example is provided with permission from Milwaukee CCO/CCE in Appendix V.

Accrual accounting allows a complex organization to have a more realistic picture of its financial health than cash based accounting does. However, it does demand that an organization also carefully watch its cash flow since it could be doing great "on paper," yet lack funds to make the next payroll.

Your accounting system should also be designed to allocate costs. Cost allocation is the assignment of costs to specific programs or operating centers. For example, a full-time physical therapist might have 30% of her salary assigned to "Administration" and 10% of her salary assigned to each of seven teams. The identification of "cost centers" is determined by your information and decision making needs. For example, a system

could track costs by team, geographic location, member, or all three. The more detailed the information generated, the more complex the system needed.

Another key element to your financial management system is your payments to contractors, or third parties, such as physicians, pharmacies or day centers.   This has been a particularly challenging area of management for Partnership Programs. The volume of bills alone can be overwhelming. Managers from one Wisconsin organization remember that, at start up, these bills were collected in a shoebox, which quickly overflowed. It became clear that the existing "Accounts Payable" system could not handle the number of claims nor provide the type of reporting needed. To address this situation, several Partnership Programs have contracted with third party administrators (TPAs) to receive, pay and report on these claims. This seems to solve some problems but not others since TPA reports are not yet easily integrated with other organizational financial reports. (See discussion of this issue under Information Systems).

Your financial system must provide adequate information for both internal and external reporting requirements.

Voice of Experience

Staff of the Community Care Organization in Milwaukee say, "You will live or die by your statistics."   Make sure the data they are based on are good.

You will need to produce, at minimum, the following reports:

- **Statement of Financial Position**.

  This is the nonprofit version of a Balance Sheet and reports the organizations' assets, liabilities and net assets on a specific date. ("Net assets" were previously known as a nonprofit organization's fund balance). It should be reported on a monthly and annual basis.

- **Statement of Activities.**

  This is the nonprofit version of a Profit and Loss Statement. It reports revenues, expenses and the resulting change in net assets. Incurred But Not Reported (INBR) expenses must be estimated and included in this report for it to be meaningful. (The "Statement of Activities" was previously called a nonprofit's Statement of Revenue, Expenses and Changes in Fund Balances). This report is prepared on a monthly basis.

- **Current month and Year-to-date budget reports**.

  These should include your projected budget amounts for each expense category, your actual expenses for the category and note any variance between the two. Some categories may represent a one-time expense, so a variance is to be expected for much of the year. It may be important to provide explanations for these to board members who may be unfamiliar with the details of the budgeting process.

- **Statement of Cash Flow and Cash Flow Projections**.

  The Statement of Cash Flow, which many nonprofits produce just once a year, reports all of the organizations' receipts and disbursements and

summarizes the change in cash available to the organization. Partnership

Programs should produce this on a monthly basis, particularly during start-

up when cash flow may be problematic. The Statements of Cash Flow

help monitor and produce Cash Flow Projections, which should be

developed on an annual, quarterly and monthly basis. These will help the

organization determine when it might face a cash shortage and will need to

draw on resources such as a line of credit.

Board

As your organization changes, so must your board. New members, who can link the

organization to constituencies such as service organizations and consumers may need to

be added. You will also need some members who understand managed care and the

finance and quality issues it may raise for your organization.   Skills, knowledge and

constituent representation are important on a Partnership board, but so is attitude. As one

Partnership manager put it:

"We had a tremendously supportive starting board… by and large the

members had growth outlook perspectives, collaborative mindsets, trust

mindsets, but were questioning too. The decisions to go into personal

supportive care and into other counties really were board decisions. Yeah,

the staff made recommendations, but we could not have done it without

their thoughtful approval."

The board may need help in developing an appropriate style of oversight for the complex organization you are becoming. Partnership organizations found it helpful to contract for assistance in board training and development and to adopt a board-operating model similar to the Carver Policy Governance Model.

Policies and Procedures

New Partnership Programs need to create an infrastructure of the policies and procedures that will be needed to "hit the ground running." All organizations need various types of formal policies, such as human resource policies. These may need to change as the organization enlarges simply because laws often require new sets of formal policies for organizations with more employees.

However, Partnership Programs also must have policies and procedures related to resource allocation and team operation. Although these may change over time, it is crucial to have them in place when the first members are enrolled.

Development of resource allocation guidelines is a particular challenge in a new Partnership Program. One problem is related to the shift from just a few members enrolled in the beginning to a much larger number and increasing caseloads. Simply put, with program start-up the team may only have a few consumers to worry about. Under these circumstances, the tendency is to give everything that is requested, and, frequently, to give consumers many things they have not asked for and may not want. When the initial enrollment is low, team members who have long been frustrated with lack of resources and an inability to spend enough time with consumers/patients may react by

becoming overly involved in the consumers' lives and creating expectations for service levels that cannot be sustained when the program is in full operation.

This is made even more difficult by the sudden absence of rules to direct the practice of health care providers. No longer controlled by strict guidelines from insurance companies or government regulations about level of service, it was extremely difficult for staff to determine what the right level might be. Nurses, in particular, have lived with Medicaid, Medicare & Insurance rules for so long they find it difficult to forget those restrictions and develop service level criteria based on more meaningful, appropriate and responsive criteria. This issue deserves considerable discussion up front.

It is also important to establish some guidance for agreeing to or denying a consumer's request. These resource allocation decisions are often where the habits, approaches and values of the health care and long-term support systems and providers first clash. Having clear criteria that simultaneously reflect consumer choice, research on consumer perspectives and practice standards related to illness care is vital. Developing these criteria and associated guidelines early in the planning process provides a starting point and a touchstone for continuing dialogue on service provision. It also provides some greatly desired structure in a program that needs to remain flexible. This is the point where the integration of nursing and social work expertise is most important (see Appendix D).

Adoption of a Partnership Program will require a clear system that supports the teams' authority to make decisions for members' care. However, there will be circumstances when the teams will need to consult other members of the organization. It is important

that teams know the extent and limits to their authority – and that these will change as the organization becomes more experienced providing a variety of types and levels of care. See Appendix Z for a sample of the Service Authorization Protocol from one of the Partnership Programs.

Voice of Experience

Once an organization has had repeated experience handling a particular type of situation, a protocol can be developed that allows decisions about it to be handled at the lowest organizational level possible.

Contracting

The Partnership Programs are each required in their contract with the Wisconsin Department of Health and Family services to have signed contracts for all required Medicare and Medicaid services. Before the Department allows enrollment, the Partnership programs must demonstrate that they have a sufficient number of appropriate providers to meet the care needs of their enrollees. The Department also has a list of required provisions that must be included in all provider contracts. These include grievance and appeals, reporting requirements, quality improvement data, emergency services, etc.

Voice of Experience

Developing contracts with provider organizations can take a very long time. Start early.

The Partnership Programs recommend that organizations plan for the time it will take to identify and meet with potential providers. It may take several months for larger providers such as hospital and physician systems to review and sign agreements. Multiple meetings with various representatives of a potential provider (management, financial and legal) may need to be arranged before discussion and agreement on terms and reimbursement for services will be finalized. Many provider organizations may have parent companies that will also have to review the contract. It will be important for organizations to start to develop contract language and meet with potential providers early in the process.

Since establishing contracts can take a long time, it is important to have them in place when the "doors open." Partnership Programs should not wait until a contract is needed with a particular provider to begin developing it. Contracts need to be in place with hospitals, nursing homes, CBRFs, home care organizations, transportation providers, physical therapists, clinics with primary care and specialists, DME providers, and dentists.

Voice of Experience

Managing contracts takes time and expertise. Organizations will probably need to hire a person whose primary responsibility is to develop, monitor and update contracts with the Partnership program's provider network. This is a never-ending task.

Partnership staff recommend taking a proactive approach to negotiating contracts. Remember that, as the payer, you will have authority and leverage that would not

otherwise be the case. This can often be used to promote both the quality and the cost effectiveness of care. Reminding contractors that they have contracts in which they agreed to provide a particular service or a specified level of service in return for reimbursement, gives you greater influence over the care than would otherwise be the case. For example one nursing home was not providing the level of daily care and rehabilitation that was expected and specified in the contract. Partnership staff were able to influence the level of care, increasing both rehabilitation and daily care by reminding the nursing home administrator that there was a contract in place to provide it and that reimbursement would be dependent on providing the contracted services. There were very few occasions when a Partnership site was unable to positively influence the care and resorted to contract termination.

When you are writing your contract for services you will need to have specific language that clearly defines your expectations for services, reimbursement, and quality. This language will apply to any subcontracting situations (See Appendix W for an example of a Partnership Contract). Contracts should include:

- Clear specification of the nature and level of service,

- Specific definitions of generic service terms such as 'residential,'

- Outcomes for which the subcontractor will be responsible,

- Problem solving and communication mechanisms expected from the contractor, and

- Contractor expectations of the Partnership Program.

Risk Management

Partnership organizations manage several types of risk. The management of members'
health risks is discussed in Part 1 of this manual. This section will address the
organization's financial risks as well as the personal and professional risks its employees
face. Strategies for managing each of these are discussed below.

Outlier Protection

In Wisconsin, the state allows some high-cost Medicaid covered services for members to
be reimbursed based on actual cost, rather than incorporating them into the capitation
rate. These include the costs for ventilator-assisted members and those who have a
confirmed diagnosis of AIDS or are HIV positive and are on retroviral drugs.

Reinsurance

Partnership Programs have reinsurance policies on their membership to cover catastrophic hospitalizations and transplants. Reinsurance products vary, however. As with most insurance products, the cost of reinsurance is directly tied to the dollar amount established for payment. In other words, greater protection (less risk to the Partnership organization) is more costly. Partnership Programs have found it challenging to find affordable reinsurance for their programs for a number of reasons, including the risks associated with their targeted population and their relatively small number of enrollees.

Risk Reserve

An organization developing a Partnership Program must plan for adequate solvency protection to protect members and their business. There are a number of ways an organization can arrange for this protection. One way is to establish a risk reserve specifically for this purpose. Other methods may include a letter of credit that allows the organization to secure funding regardless of their financial condition.

The Department of Health and Family Services established a Risk Reserve for the Wisconsin Partnership Programs. It requires a Partnership organization to maintain a balance of 30 days of Medicaid revenue in a Risk Reserve, up to a maximum of $2,000,000. The Department also requires an organization to establish and maintain a separate depository or depositories or investment accounts to receive the contributions required. The risk reserve fund account is to be established through state or federally licensed or chartered organizations in good standing. A maximum of 70% may be invested in high-grade securities. If the reserve balance drops below the required level

due to fluctuations in the market, the Partnership organization will be required to make up the balance from other sources. The funds accumulated in this account are not to be intermingled with other funds of the organization.

In Wisconsin, the Partnership organizations received a special waiver from the Wisconsin Office of the Commissioner of Insurance (OCI) exempting them from a state law which would have required them to have an HMO license and, therefore, have their risk reserves regulated by the OCI. If the Partnership Programs should become licensed as an HMO in the state of Wisconsin, then their risk reserves and financial information would be regulated by the OCI.

Personal Liability and Safety

Potential Partnership Programs must also consider how the program may influence employees' personal liability and safety and ensure that systems are in place to protect them. For example, an accounting error in a nonprofit organization can be seen as a correctable mistake. When accounting for federal Medicaid dollars, such as error could be considered fraud. Personal care employees may face risks to their health and safety when entering members' homes and performing certain tasks. These risks must also be considered and managed. Education and training of staff on risk identification and personal safety strategies, policies, and procedures and consideration of how and where after hours services are delivered and by whom all need to be considered. Collaborating with local police and other providers can be helpful.

Quality Improvement

The state requires the Partnership Programs to demonstrate outcomes and have programs in place to meet a number of quality assurance, quality improvement (QA/QI) and external review measures. The outcome measures are to ensure the ongoing quality assessment and performance improvement of services provided to members. These include annual reports to the contracting state agencies. In Wisconsin, this is the Department of Health and Family Services. These reports document:

- Access to health care has been reviewed and, if appropriate, steps have been taken to improve such access,

- Physician credentialing,

- Overall member satisfaction of at least 80% and,

- Improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and participant satisfaction.

To meet these needs, Partnership Programs are required to have QA/QI programs that can provide data to the state and/or develop written policies on access to health care, provider selection and evaluation, members' feedback and, utilization management. Partnership Programs must also assist the Department (and any external quality review organization under contract with the Department) in identifying and collecting information required for on- or off-site medical chart reviews and interviews with care teams and members.

External Capacity Development

State Relationship

Organizations that are considering adopting a Partnership program must be prepared to work closely with their state government. This complex relationship can be a challenge at times to both parties. The state agency is, at times, a "business partner" with the developing Partnership program, but is at all times a regulator of the Partnership organization. This can make for a complicated and occasionally contentious relationship. The State has a vested interest in the success of the Partnership organization while at the same time it must act as a watchdog, since it has both the responsibility to define program oversight and the authority to stop enrollment if it has concerns about access, quality or financial issues.

Organizations will need to have the necessary resources in place to constructively participate in discussions concerning provisions included in their contract with the state agency. They will want to make certain they fully understand what is being required and able to successfully negotiate language in instances where they may be unable or unwilling to meet proposed requirements. Contracting with a government agency will take patience and resources; organizations will need to make certain that meeting state requirements does not unnecessarily detract from developing infrastructure and the management of care for their members.

Most importantly, organizations will need to understand how the state reached the program's reimbursement rate. Potential Partnership organizations will need to be able to determine if the rate is adequate to meet the service needs of their members while

maintaining financial solvency.   Reimbursement rates are usually established annually and organizations need to be prepared for limited or, in some cases, no increases as they establish and grow enrollment.

Enrollment Network

Organizations will want to begin to work with local governments, physicians and other community-based providers to identify persons who may be eligible for the Partnership Program. The Wisconsin Partnership Programs received the majority of their initial referrals from county governments who were either providing long-term care services or had a list of persons waiting for services. Over time, however, as the programs become better recognized and appreciated, the Partnership Programs received referrals from a variety of sources such as community-based physicians, providers of residential housing and services, hospital discharge units and, families/friends of enrollees.

One of the biggest challenges for the Partnership Programs was to identify the initial number of eligibles necessary to get the program off the ground and then to maintain a steady number of referrals coming into the program each month to grow and maintain the desired enrollment. The Partnership Programs reported that while they may receive a relatively large number of referrals, many persons referred do not qualify for Medical Assistance or do not meet the needed level of care. In addition, there will be a significant number who are not comfortable joining a managed care program. The decision to join Partnership is often times made not only by the potential enrollee but also includes members of his or her family. You will be educating and working with a number of family members who will all be involved in the decision. Organizations will have to be

prepared to provide on-going education and outreach to the community to maintain desired enrollment. The members of your Steering Committee will be key in understanding and identifying persons who both qualify and may be best served in the Partnership model.

Voice of Experience

Organizations developing a Partnership Program will need to seek a large number of referrals at the start because only 5 – 10% of the persons referred may actually enroll. Partnership Programs also need to invest staff time and resources to continually maintain an adequate number of monthly referrals.

Provider Relationships

There are a number of ongoing activities associated with establishing, educating and maintaining a large network of health and long-term care providers. In addition to drafting, negotiating and executing the terms of a contract, the Partnership organization will need to have policies and procedures in place to ensure that services to their enrollees are appropriate and meet the quality requirements of their program. The contract language may specify program requirements, however, it will take well thought-out, developed protocols and knowledgeable, dedicated staff to ensure that providers are delivering services in a manner consistent with Partnership Program's philosophy of care.

Decision Point

Each of the following items on the checklist needs to be in place before you begin enrollment.

Capacity Development Checklist

		Not Sure	No	Yes
1.	The organization has credibility among consumers and providers in the community	☐	☐	☐
2.	The organization has secured contracts with adequate and appropriate service providers	☐	☐	☐
3.	The organization has developed a physician panel	☐	☐	☐
4.	The organization has developed adequate and appropriate organizational and clinical expertise	☐	☐	☐
5.	The organization has developed an adequate and appropriate information system	☐	☐	☐
6.	The organization has developed appropriate policies and procedures	☐	☐	☐
7.	The organization has developed an integrated care management team	☐	☐	☐
8.	The organization has systems in place to meet government regulations	☐	☐	☐
9.	The organization has developed an appropriate financial infrastructure and adequate payment mechanisms	☐	☐	☐